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HAWAII MEDICAL JOURNAL

VOLUME 31 / NUMBER 1



283268

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension; thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and GI tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmologic examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical



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coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information

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Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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VOLUME 31, NUMBER 1

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arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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(For full prescribing information, see package circular.)

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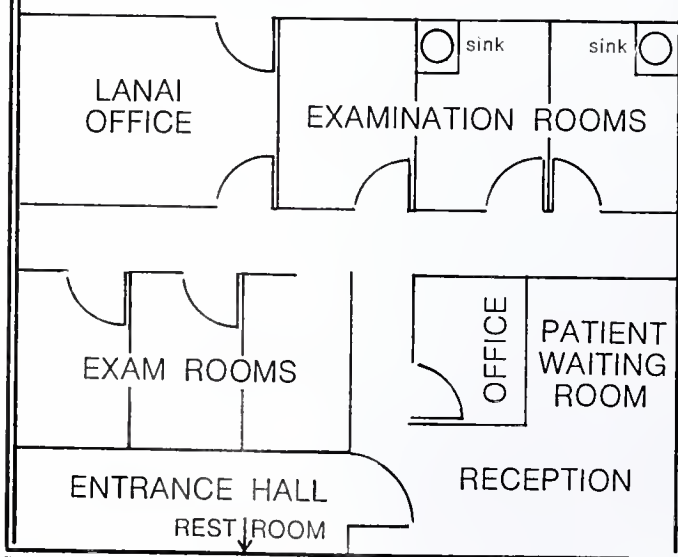
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Investigation of a Treatment Method:

Relative Hypoglycemia

JUAN CARLOS DE TATA, M.D., *Honolulu*

ADHERENCE to certain diets, usually high in carbohydrates and caffeine, and the appearance of certain symptoms, point to the diagnosis of relative hypoglycemia. Nevertheless, patients with these characteristics are often diagnosed as neurotics, and as a syndrome, hypoglycemia has been confused with neurosis or psychosis. The investigation described in this paper did not minimize the importance of the psychiatric syndrome. Instead, it tried to establish the concomitance of psychological symptomatology and the determination of the hypoglycemic syndrome. Our objective was to do that by clinical examination and a 6-hour glucose tolerance test. Treatment consisted basically of diet and, where indicated, medications such as calcium, atropine, and mild tranquilization.

The investigator became interested in hypoglycemia through his personal experience. For nine months (July 1964 to March 1965) he had suffered from headaches, dizziness, threatened fainting, fatigue, sweating, cold hands and feet, and occasional muscle cramps. He had consulted a number of doctors, and various diagnoses had been offered. Finally, a 3-hour glucose tolerance test revealed a drop of 30 points, from 78 mg fasting blood sugar to 48 mg in the third hour.

By coincidence, at just this time, the investigator read a note by Harry M. Salzer, M.D., of the University College of Medicine in "Frontiers of Hospital Psychiatry,"¹ which stated that neuropsychiatric illness is often caused by relative hypoglycemia. Contact was made with Dr. Salzer and an interesting exchange of ideas followed.

In this paper we are not trying to purport to support the thesis that relative hypoglycemia is a

common "cause" of neuropsychiatric illness; we also would like to think of it as a "contributing factor" or "even a consequence" (eg, result of depressive anorexia).

DR. SALZER'S FINDINGS

Dr. Salzer had suggested that relative hypoglycemia could be frequently related to neuropsychiatric illness. He enumerated the symptoms as follows:

Major psychiatric symptoms: depression, insomnia, anxiety, irritability, lack of concentration, crying spells, phobias, forgetfulness, confusion, asocial and antisocial behavior, and suicidal tendencies.

Major neurological symptoms: headaches, dizziness, internal and external tremulousness, numbness, blurred vision, staggering, fainting and blackout, and muscular twitching.

Major somatic symptoms: exhaustion, fatigue, bloating, abdominal spasms, muscle and joint pains, backache, muscle cramps, colitis, and convulsions.

Dr. Salzer pointed out that patients with relative hypoglycemia have been incorrectly diagnosed as having schizophrenia, manic depressive psychosis, or psychopathic traits, since the syndrome mimics various neuropsychiatric disorders. The syndrome can be readily detected with a 6-hour glucose tolerance test. The test should be interpreted as *positive* if there is a blood sugar drop of 20 mg or more below the fasting blood sugar level, and as *suspicious* if the drop is from 10 to 20 mg below the fasting level. According to Dr. Salzer, treatment would require strict adherence to a regime of a high-protein, low-carbohydrate, caffeine-free diet, and frequent feedings. He also

From Diamond Head Mental Health Center.
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recommends calcium glycerophosphate, administered intragluteally. Because the psychoneurological manifestations of hypoglycemia are so varied, he thought it essential that every patient undergoing psychiatric or neurological evaluation be given a 6-hour glucose tolerance test as a routine procedure, and be asked to provide a complete report of his diet.

Dr. Salzer described his findings in a paper presented at the National Medical Association convention in January, 1966 and published in the Association's Journal.² A series of cases are reviewed in this paper. The author comments that patients could be spared years of suffering, electroshock therapy, and the hazards of taking sedatives, stimulants, and tranquilizers if their ailments were correctly diagnosed as relative hypoglycemia, and they were taught what they should and should not eat.

According to Dr. Salzer, "Many patients with relative hypoglycemia who are hospitalized show improvement largely because they are on a better diet in the hospital. Incidentally, some of the tranquilizers may bring about improvement because they elevate the blood sugar level."²

We would not say that diet is a main force for change in these patients because we have to consider also intensive psychotherapy, medications, placebo effect of diet, and that improvement could be just coincidental or by the power of suggestion.

FINDINGS OF OTHER INVESTIGATORS

Other investigators reported findings similar to those of Dr. Salzer. Among these were Martin S. Buehler, M.D.,³ who included the findings of Drs. A. Hoffer, Robert Meiers, Jack Ward, and Allan Cott.

Drs. Hoffman and Abrahamson⁴ had found that diabetics, as a rule, are very phlegmatic people, singularly unaffected by many ailments, and having fewer allergic disorders, peptic ulcers, and rheumatic fever than other diabetics. They found that in diabetics, hypoglycemia was uniformly present, and that manifested hypoglycemia could be accompanied by marked psychic phenomena, such as depressive states, anxiety, and other symptoms which had been lumped together as "neurosis."

Many patients with hypoglycemia have been found to have a drop in their calcium, so that *hypocalcemia* seems usually to coexist with hyperglycemia. Sam E. Roberts, M.D.,⁵ in treating dysfunctions in the cochlear branch of the eighth nerve, utilized calcium gluconate as the agent of choice to improve some of these conditions. He found it "of value in non-inflammatory edema, in

thrombotic states, and in hypoglycemia, which is frequently associated with hypocalcemia." (The preparation used was Calphosan (R), Carlton Pharmaceutical Company.)

Drs. Hoffman, Abrahamson, and Josephson⁶ explained that the normal serum-calcium level lies between 9 and 11 mg per 100 cc. Of this, about 2.5 mg per 100 cc exists as ionic calcium in equilibrium with an inorganic phosphate of the blood. About 4 mg per 100 cc are combined with the blood proteins and the rest occurs as an un-ionized complex, thought to be the citrate of some similar salt. This last fraction is apparently under the influence and control of the parathyroid hormone. They explained that replenishment of diminished serum-calcium can be accomplished in several ways. *Oral administration of soluble calcium salts* is effective, but very slow. Most of the ingested calcium is precipitated in the bowel as phosphates, carbonates, and soaps. Only a small portion is absorbed. Therefore, while alimentary calcium suffices to insure skeletal growth and to maintain a physiological level in the blood, when there is need for an increase in serum-calcium in a therapeutically reasonable time, a more rapid absorption is essential. The *intravenous administration* of calcium solutions effectively raises the serum-calcium, and this route is most frequently employed. Unfortunately, the effect is too transient, since the added calcium is excreted into the urine within a few hours. Most of the commercially available calcium solutions cannot be given *intramuscularly* because they often produce painful indurations which sometimes break down into slowly healing sloughs. The subcutaneous tissues are particularly sensitive and the sloughing is the frequent sequella to leaking from the vein. Calphosan (R) is a 1% solution of calcium lactate and calcium glycerophosphate in normal saline. It can be administered by any parenteral route. It has been given routinely in 10 cc doses intragluteally, injections being absolutely painless and leaving no induration. The pH is 7.2, whereas all the other commercial calcium solutions that they were able to test had acidity ranging from 5.5 to 4.5. These were all 10% solutions, and Calphosan (R) is only 1/10th as concentrated. Dilution of the ordinary solutions to corresponding strength (ie, with 9 volumes of water) should theoretically raise the pH by 1 unit which would still leave them too acid to be tolerated intramuscularly. The recommended administration was four weekly injections of 10 cc which made the level of calcium remain high for almost a year.

Gerald I. Kurtz,⁷ described the relief of allergic disorders with a double calcium and phosphate salt. He stressed that some investigators have

assumed that there is an actual or relative calcium deficiency in allergies, based upon the belief that increased capillary permeability due to such a deficiency constitutes a fundamental characteristic of the pathologic physiology of hypersensitivity. In this connection it may be noted that in 1966 the fifth printing of the book, *Goodbye Allergies*, appeared. It is by a layman, Judge Tom R. Blaine, with an introduction by Sam E. Roberts, M.D.⁸ This book points out that "patients with hypoglycemia and hypoadrenocorticism (inadequate hormone production by the cortex of the adrenal glands) usually have hay fever, asthma, migraine, hives, or eczema, and frequently suffer from respiratory, gastrointestinal, and genitalurinary disorders. The control of such a syndrome by diet, medication, and avoidance or treatment of emotional upsets is stressed. Doctors have found that when a low blood sugar condition is corrected, when the adrenals are put into proper working order, and the patient starts to relax, he has fewer allergies." In this context, the writer believes that the utilization of hypnotic techniques of relaxation is extremely important.

INVESTIGATION AT DIAMOND HEAD MENTAL HEALTH CENTER

With the above data in mind, an investigation was undertaken in 1966-67 in the outpatient clinic of the Diamond Head Mental Health Center, Honolulu, Hawaii, of the possible relationships between complaints similar to those listed by Dr. Salzer, and allergies and hypoglycemia. Patients were selected who complained of depression, insomnia, anxiety, headaches, dizziness, fainting, exhaustion, fatigue, sweating, and who also reported very poor dietary habits or large ingestion of carbohydrates or coffee. The purpose of the investigation was to see how these patients responded to treatment consisting of a modified Seale-Harris diet and tranquilization, either by medication or by relaxation through hypnosis.

Difficulties arose because the clinic, financed by the Department of Health, did not have the facilities for making glucose tolerance tests and serum-calcium determinations, and most of the patients could not afford the fees of a private laboratory. It was, however, possible to obtain glucose tolerance tests for a total of 21 patients (in the interests of brevity, not all 21 charts are reproduced), 12 of whom had positive hypoglycemic curves, 8 of whom had suspicious curves, and 4 of whom had flat curves. Of the 12 with positive hypoglycemic curves, 2 had dysinsulinic curves, 2 had severe asthma and 2 were alcoholics.

The patients were told to follow a specific diet. With those patients who were cooperative in fol-

lowing the diet, very good results were obtained. After three months, they were able to deviate from it to some extent, and yet continue to do well. Other patients, however, reported reappearance of symptoms when they did not follow the diet strictly. Because of the neurotic traits of some patients it was found best for them to adhere "religiously" to the prescribed diet.

Because of poor transportation facilities, the patients were unable to get to the clinic as often as was desirable. For this reason and also because of lack of facilities in the clinic, patients could not be treated with calcium injectable.

DIET INSTRUCTIONS TO PATIENTS

Immediately on Arising: 4 to 6 oz. orange juice, frozen or fresh; or 1 medium orange (orange juice or orange allowed *only once a day on arising*).

Breakfast: Fruit or 4 oz. juice (unsweetened); 1 or 2 eggs with or without 2 slices of bacon or ham; **ONLY ONE** slice of any bread or toast, but with plenty of butter or margarine; beverage.

9:30 a.m. (2 hours after breakfast): 4 oz. juice or milk (or eggs or cheese).

Lunch: Meat, fish, cheese or eggs; salad (large serving of lettuce, tomato or Waldorf salad, with mayonnaise or French dressing); vegetables if desired; **ONLY ONE** slice of any bread with butter or margarine; dessert; beverage.

2-3 p.m. (2 or 3 hours after lunch): 4 oz. milk (or egg or cheese).

1 hour before dinner: 4 oz. juice (unsweetened).

Dinner: Soup if desired (not thickened with flour); liberal portion of meat, fish, or poultry; vegetables; **ONLY ONE** slice of bread if desired, but with plenty of butter or margarine; salad, dessert; beverage.

Every 2 hours until retiring: 4 oz. milk and/or a small handful of nuts or 1 or 2 saltines, but must be with cheese or dietetic peanut butter.

DO NOT GO TO BED HUNGRY

If wakeful during the night: Eat a high protein snack (milk, cheese, meat, eggs).

Meat, or milk, or nuts, or 4 oz. of allowable juice may be taken hourly throughout the day if underweight or if symptoms are severe.

FOOD AND DRINK ALLOWED

Allowable Vegetables: Fresh, frozen or canned: Artichokes, asparagus, avocado, beets, black-eyed peas, broccoli, brussels sprouts, cabbage, cauliflower, carrots, celery, corn, cucumbers, eggplant, garlic, kale, lentils, lettuce, lima beans, mushrooms, okra, onions, peas, peppers, pumpkin,

radishes, sauerkraut, soy beans, spinaeh; squash, string beans, sunflower seeds, tomatoes, turnips, watercress. (Corn, lima beans, lentils and peas are least desirable.)

Allowable Fruits: Fresh cooked, or unsweetened, frozen or canned: Apples, apricots, berries, cherries, fresh coconut, grapefruit, kumquats, lemons, limes, mango, melon, papayas, peaches, pears, pineapple, and tangerines—with or without sugar. Sweeten with saccharin, Sucaryl or Sweeta.

Allowable Juice: The following if unsweetened: Apple, grapefruit (orange juice or orange only on arising), pineapple, tomato, vegetable, Vegemato, V-8; sweetened only with saccharin, Sucaryl or Sweeta. *Knox gelatine* may be added for protein.

Allowable Beverages: Above juices, dietetic carbonated drinks except cola (brand name is Canada Dry Low Calorie or Cotts') creamed or plain buttermilk, *Kaffir tea, *Redbush tea, milk, vichy, Fizzies (cola Fizzies permitted), Sprite and Fresea, *Sanocaf (coffee imitation) and *Kappa tea (*obtainable at health food stores).

Allowable Desserts: Fruit, unsweetened gelatin, Dezerta fruit flavors, junket from tablets only and the following *dietetic* products: Candy (except chocolate), gum, fruits, ice cream, jelly or puddings—sweetened with saccharin, Sucaryl or Sweeta, but *not* sugar, syrup or honey. Dietetic maple syrup permitted.

ABSOLUTELY NONE OF THE FOLLOWING

Sugar, honey, candy (including chocolate); other sweets, such as: Cake, chewing gum, JELLO, pastries, pie, puddings, sweet custard, sweet jelly or marmalade and ice cream.

Caffeine—ordinary coffee, and even coffee substitutes such as *Sanka* and *Decaf*: tea, beverages containing caffeine such as *Coca-Cola*, *Pepsi Cola*, other cola drinks, *Ovaltine*, *Postum*, hot chocolate.

No ordinary carbonated drinks. *No grape, prune, or juices other than listed above.* Bananas, dates, dried fruits, figs, grapes, persimmons, plums, prunes, raisins. Macaroni, navy and kidney beans, noodles, potatoes, rice, spaghetti and ravioli. Beer, cocktails, cordials, wines.

Medications containing caffeine such as: Anacin, A.P.C., A.S.A. compound, BC, Caffergot, Coricidin, Empirin Compound, Fiorinal, Four Way Cold Tablets, Salfayne, Stanback, Trigesic. (Plain aspirin or *Bufferin* or *Measurin* permitted.)

Read the label on every can of juice, fruit, vegetable, meat and other products. Select only those containing no *syrup*, *honey* or *sugar*. (These can be found at the dietetic counters in all large markets.)

DO NOT CHANGE TIMING, TYPE OR AMOUNT OF FOOD

SUMMARY

This investigation would appear to go along with some of Dr. Salzer's views that relative hypoglycemia could be related to neuropsychiatric illness. I feel it justifies the utilization of a 6-hour glucose tolerance test as a diagnostic tool, and would give some indication that multiple complaints might be lessened by control of the diet, as well as medication, therapy and relaxation techniques.

This was a preliminary report and it has been expected that in the future, with more funds and better facilities, this type of studies could be continued.

CASE REPORTS

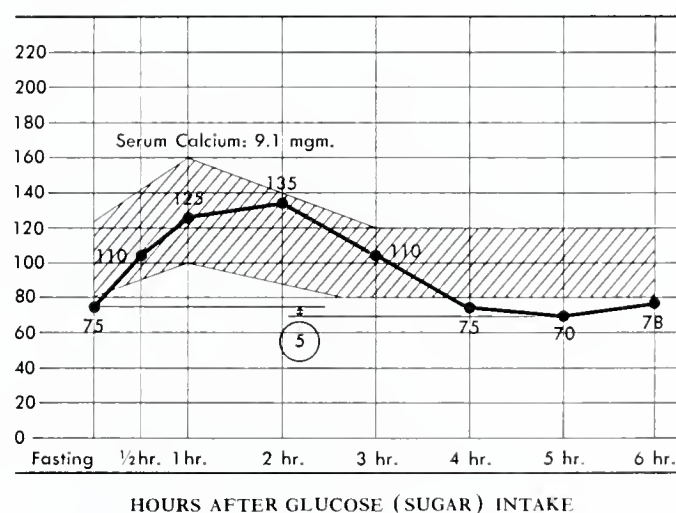
On the charts relative to each of the following cases, the left margin shows the blood sugar in milligrams (mgm) per 100 cc or 3 1/3 oz. (100 mg of sugar per 100 cc is the same as 1 1/2 grains of sugar in 3 1/3 oz of your circulating blood.)

Shaded area shows normal range differences. The heavy, dark line indicates the glucose (sugar) tolerance curve.

Normally sugar will be lost through the kidneys at 160 to 200 mgm. At 1/2 hour the blood sugar level should not exceed the fasting level by more than 75 mgm; the one hour level should not be over 160 mgm.

A drop of 10 points below your fasting level is considered suspicious of relative hypoglycemia and a drop of 20 or more points is definite. A flat response is also considered relative hypoglycemia.

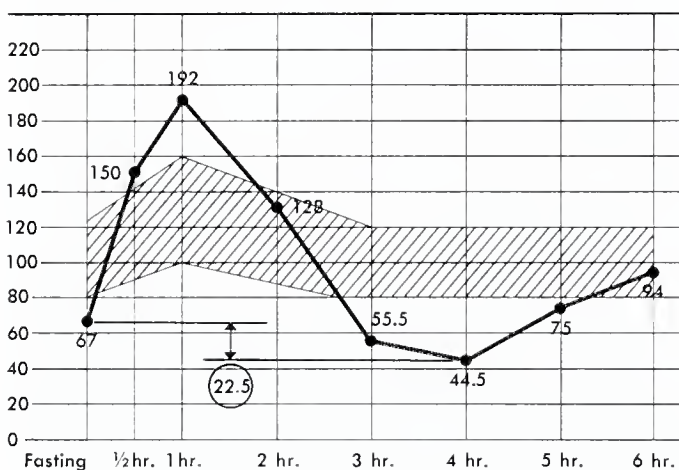
FIG. 1.—Heavy, dark line indicates glucose (sugar) tolerance curve. Case 2.



Case 2, female, example of "suspicious curve." Patient was referred to the clinic in December, 1966. She had a previously long history of mental and marital difficulties. Diagnosis: Schizophrenia, Chronic Undifferentiated. Complaints: irritability, dizziness, headaches, diaphoresis, anorexia or extreme hunger, and vicarious confusion. We suspected that concomitantly with her schizophrenia, she might have a relative hypoglycemic syndrome. Six-hour glucose tolerance test was performed

as late as April, 1967, due to patient's poor cooperation. Although the results were only "suspicious," she appeared to operate at a "low level of glucose." After following our recommended diet, she looked "healthy" for the first time in a long time, symptoms disappeared, she began to work and she lost her irritability.

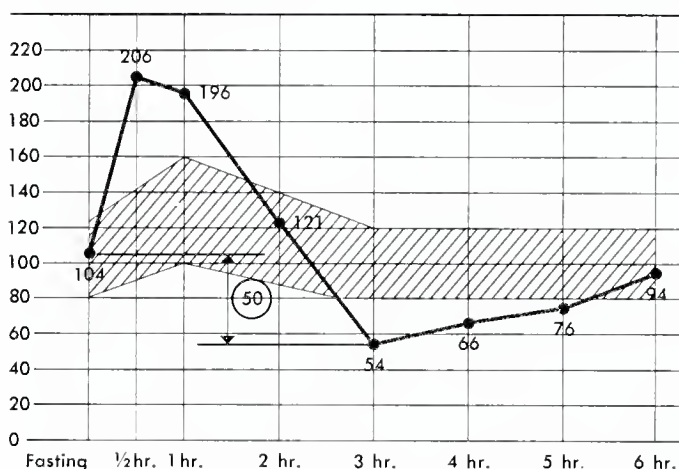
FIG. 2.—Heavy, dark line indicates glucose (sugar) tolerance curve, Case 11.



HOURS AFTER GLUCOSE (SUGAR) INTAKE

Case 11, female, 43-year-old patient was admitted to Leahi Hospital, Mental Health Unit, for alcoholism of 15 years duration. Total stay, 102 days. Diagnosis: Alcohol Addiction, Laennec's Cirrhosis and Hypoglycemic Syndrome. Her curve shows the type of "dysinsulinic patient." Treatment: Seale-Harris diet, Librium, vitamin B, Calphosan, Belladanal. She did very well in the hospital, was discharged as improved and there was no re-hospitalization to our knowledge within the following two years.

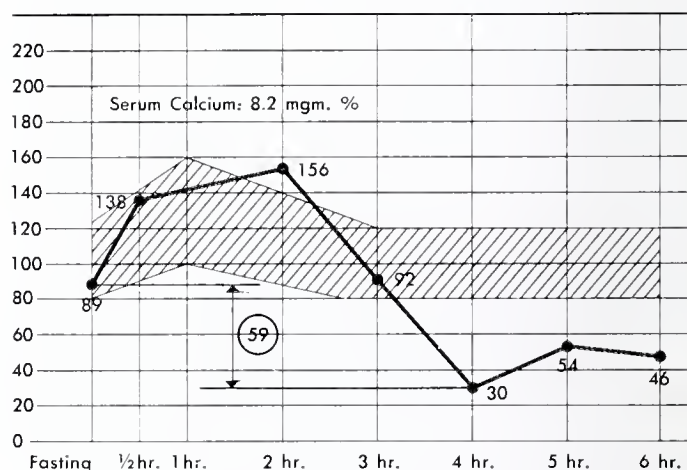
FIG. 3.—Heavy, dark line indicates glucose (sugar) tolerance curve, Case 20.



HOURS AFTER GLUCOSE (SUGAR) INTAKE

Case 20, female, 51 years old. Case opened September, 1966, complaining of innumerable traumatic experiences in life and also "epileptic syndrome" for which she was taking Dilantin and Phenobarbital. She presented herself with a "psychotic-like syndrome" and extreme depression. Her 6-hour glucose tolerance test showed a "dysinsulinic curve." Treatment: psychotherapy, Seale-Harris diet, Tofranil and Bellergal. Patient had an excellent remission, started working, reduced her Dilantin, Phenobarbital, discontinued the Tofranil and was able to continue in remission for the following two years.

FIG. 4.—Heavy, dark line indicates glucose (sugar) tolerance curve, Case 21.



HOURS AFTER GLUCOSE (SUGAR) INTAKE

Case 21, 53-year-old female; 15 years of complaints of bronchial asthma. Left ovarian tumor removed in 1940. History of transient leukopenia, anemia and hypertension, allergy to aspirin and sensitive to Sparine. Admitted to Hawaii State Hospital because of excessive praying, crying and regressed, almost catatonic. From there transferred to Leahi Hospital, Mental Health Unit; total hospitalization 239 days. Diagnosed as severe hypoglycemic syndrome in August, 1966. She had been given different drugs such as Atarax, Librium, Quadralin, Marax, chlorpheniramine, potassium iodine, atropine and Bellergal. Most drugs were discontinued after August, 1966. She was placed on the Seale-Harris diet and received the series of Calphosan IM. She improved and had no further psychiatric problems. Diagnosis: schizophrenia, chronic undifferentiated (in remission), relative hypoglycemic syndrome, and bronchial asthma. After her discharge, she abandoned her diet, ate extremely poorly and became upset again. She was readmitted to Leahi Mental Health Unit. She was again given the Seale-Harris diet and atropine. She improved in less than two weeks. Improvement was maintained during hospitalization and was discharged to a care home where her diet could be controlled and improvement was maintained for two years.

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*The ethnic aspects of suicide have a bearing
on suicides among Japanese in Hawaii.*

Japanese Suicides in Honolulu, 1958-1969

DOMAN LUM, Th.D., *Honolulu*

There have been numerous studies of suicide in different countries around the world. In recent years, several suicidologists have focused on ethnic and cultural variations in suicide (Hayakawa, 1957; Bohannon, 1960; Devos, 1962, 1968; Hendin, 1964; Iga, 1966, 1967, 1968; Reynolds and Ohara, 1967; Hippler, 1969). While the vast majority of these articles emphasized one particular cultural and racial group, there have been very few comparative suicide studies on single pluralistic societies.

IN THE December, 1968 issue of *The Bulletin of Suicidology*, Richard A. Kalish of the School of Public Health, University of California, Los Angeles, published an article entitled, "Suicide: An Ethnic Comparison In Hawaii."¹ Utilizing 1959-1965 suicide data from the Hawaii State Department of Health, Kalish undertook a demographic investigation of suicides and suicide attempts in Hawaii related to ethnicity, age, sex, and other variables. Regarding ethnic differences, Kalish found that Hawaiians have the highest rate of both suicide attempts and death while Caucasians have the second highest rate of suicidal death and the third highest rate of suicide attempts. Furthermore, Japanese, Chinese, and Koreans showed a marked suicide increase with age, while Hawaiians,

Part-Hawaiians, Puerto Ricans, and Filipinos reflected a relatively high rate of youthful suicide. As far as methods of suicides and attempts were concerned, on the one hand, hanging covered nearly 30% of all suicides and was used by Chinese, Japanese, Koreans, and Filipinos in 40% of each group's suicides. On the other hand, the method of suicide attempts tended to be either cutting or poisoning. Concerning suicide and occupational status, Kalish discovered that the higher the occupational class, the higher the suicide rate, with the exception of Hawaiians. For his study, Kalish obtained population statistics from the 1960 census, data on divorce and illegitimacy from 1962-1965, data on crime from the Honolulu Police Department for 1964-1965, and mental hospital data from the Hawaii State Hospital Audit: Cohort Analysis of First Admissions to Hawaii State Hospital (Fiscal Year 1963-1964).

Most interesting was Kalish's finding on suicide, ethnicity, and social disorganization. European, Polynesian, and Southeast Asian groups tended to have a high rate of attempts; a low ratio of committed suicide to unsuccessful attempts; a high proportion of youthful suicides and attempts; a large proportion of shooting suicide; high rates of crime, mental hospitalization, divorce, and illegitimacy; and low occupational status. However, groups representing East Asian nations exhibited low suicide attempt rates, a high ratio of committed to unsuccessful suicides, a high proportion of suicide attempts and death among older people;

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a high proportion of hanging suicides; low crime, mental hospitalization, divorce, and illegitimacy rates; and higher occupational status.

However, at the present time Kalish's suicide statistics are temporarily in limbo. Through conversation with Hawaii State Department of Health statisticians, it was discovered that Kalish was given population statistics for the entire state, but suicide statistics only for Oahu. Thus, several of Kalish's findings should be tentatively suspended until the discrepancies are corrected.

LOCAL SUICIDE STUDY

As a follow-up of Kalish's article, Dr. Jarvis Ryals and I began a detailed study of suicidal deaths throughout the entire State of Hawaii from 1958 to 1969. Statistics were gathered and individual suicide cases were examined from the Medical Examiner's Office or Police Department of each county: Honolulu, island of Oahu; Hawaii; Maui; and Kauai. Most interesting among the various patterns of suicide according to racial groups were Japanese suicides. On the island of Hawaii, which has twice as much land area as all the rest of the islands combined, and largely rural, there were 48 Japanese suicides in the middle and older age groups. It is noteworthy that although the Japanese compose only 39.9% of the Big Island population, they accounted for 58.5% of the suicides. The predominant profile tended to be an older Japanese man, born in Japan, who hangs himself. The 10 Japanese suicide cases on Kauai, and the 34 Japanese suicides on Maui show a similar distribution.

Turning to suicides in the City and County of Honolulu from 1958-1969, there were 169 suicidal deaths of Japanese, or roughly 27% of 634 suicides over the twelve-year period. Approximately, 50% of these Japanese suicides consisted of older persons, predominantly men, who usually hung themselves. There was also a high ratio of men to women (3:1) among Japanese suicides. The average annual rate for Japanese is 8.4 per 100,000 of the Japanese population in Honolulu. In contrast, the largest single racial group of the suicides (43%) were among middle-aged Caucasian men and women who usually either shot or poisoned themselves. At the same time there was a more even ratio of male to female suicide among Caucasians (1½:1) (Table 1).

Further investigation of Japanese suicidal deaths involved intensive research of case records from the files of the Honolulu Police Department and the Medical Examiner's Office. The data reveals at least three emerging areas:

SUICIDE METHOD

Although the method of suicide is generally based on availability of means, Japanese hanging and non-hanging groups revealed significant differences. Out of 84 suicidal hangings committed by Japanese, 58% were over 50 years old, and predominantly born in Japan (Table 2). Embedded in Japanese tradition is a mythology which mentions suicide. For example, *kabuki* plays from 1600 to 1713 are by and large comedies featuring lively dances, parading, the handsome gallant visiting his courtesan favorite, and erotic and humorous sketches. However, from 1670 and through the 1700's, *kabuki* plays abruptly shifted to scenes of pathos, especially suicide and separation scenes. Love suicides, suicides of atonement, and suicides ordered by the authorities or the particular situation of the moment were an ingredient of the *kabuki*. Audiences would identify with these scenes and would achieve cathartic relief.

Japanese history records incidents of mass suicide as well as famous and legendary figures who committed suicide, lovers' pact suicides, and in some rural regions of Japan where the aged were either abandoned in the winter or voluntarily left when they no longer felt like useful members of the community.

Along with the mythological tradition, there are at least two other factors which may explain the predominance of hanging among Japanese born in Japan: *cultural transmission* and *availability of means*. Regarding cultural transmission, Lawrence H. Fuchs in his *Hawaii Pono: A Social History*² observes that out of the four major classes of Japanese (samurai, farmers, artisans and merchants), only the farmers came to Hawaii in large numbers. Whereas hara-kiri was the usual method of suicide among the aristocratic and samurai class, hanging was the common method among peasants. It may be that many Japanese suicides who were born in Japan turned to this particular method because of previous cultural patterns. Probably availability of means offers another explanation. The majority of hanging suicides were among older Japanese confined at home where the availability of rope, cloth, or a belt was at hand. Norman L. Farberow, Co-Director, Los Angeles Suicide Prevention Center, inquires:

"What is your hypothesis about the difference between hanging versus non-hanging Japanese suicides? Are you suggesting that there is some difference in the method which is related to a significant factor which should be isolated? If there is, it should be of great interest, inasmuch as, at least in my opinion, the method most often depends on what is available."³

LIFE STYLE

Nearly half of the hangings (44%), and one-third of the non-hanging (36%) group, were retired or unemployed (Table 3). The majority of suicidal deaths occurred in multiple-family living situations (hangings 74%, non-hanging 75%). Regarding the place of suicidal death, hangings

were generally at home (80%), but non-hanging suicides happened at home (58%) or outside in the community (41%). The hanging group tended to threaten (33%) or unsuccessfully attempt (18%) suicide slightly more than the non-hanging group (threats 29%, attempts 12%) (Table 4). In other words, both groups consisted of persons

TABLE 1.—City & County of Honolulu, 1958-1969: coroner's medical examiner statistics on suicide.

RACE	ACTUAL NO. OF SUI- CIDES	% OF ALL SUI- CIDES	% POP- ULA- TION	RATE PER 100, 000 POP.	AGE			METHOD										SEX	
					10- 29	30- 49	50 Over	Burn- ing	Cut- ting	Drown- ing	Shoot- ing	Gas- sing	Hang- ing	Jump- ing	Poison- ing	Others		M	F
Hawaiian	16	3	1	23	8	5	3	0	0	1	7	2	5	1	0	0		13	3
Part-Hawaiian	31	5	17	3	16	11	4	0	0	0	18	3	6	0	4	0		26	5
Caucasian	274	43	25	16	73	109	92	0	9	11	78	26	23	26	95	6		169	105
Chinese	40	6	6	9	7	11	22	0	1	2	7	1	19	6	4	0		25	15
Japanese	169	27	29	9	28	63	78	3	13	6	17	12	84	7	24	3		125	44
Korean	11	2	†	....	2	4	5	0	0	0	2	1	5	0	2	1		9	2
Filipino	55	9	7	11	16	13	26	0	5	1	17	2	23	2	5	0		47	8
Puerto Rican	6	1	.7	14	3	3	0	0	1	0	2	1	1	0	1	0		5	1
Portuguese	22	3	3	11	7	5	10	1	0	0	9	1	9	0	2	0		20	2
Others	10	2	11	....	6	4	0	0	3	0	3	0	1	2	1	0		7	3
TOTAL	634	....	....	....	166	228	240	4	32	21	160	49	176	44	138	10		446	188

Based on State of Hawaii population data for 1966-67 which excludes institutional and barracks population.
† Population statistics for Koreans were not available.

TABLE 2.—Japanese-American suicides in Honolulu: sex, age, birthplace.

	SEX			AGE			BIRTHPLACE		
	Male	Female	Total	10-29	30-49	50 and Over	Japan	Hawaii	Other
Japanese-American Hangings	61	27	84	6	29	49	44	39	1
Percentage	73%	27%	....	7%	35%	58%	52%	46%	1%
Japanese-American Non-Hangings	63	22	85	21	35	29	22	63	0
Percentage	75%	25%	....	25%	41%	34%	26%	74%	0

TABLE 3.—Japanese-American suicides in Honolulu: vocation.

	VOCATION						Total
	Professional Managerial	Semi- Professional	Unskilled Laborer	Retired or Unemployed	Patient or Prisoner	Student	
Japanese-American Hangings	5	18	17	37	5	2	84
Percentage	6%	21%	20%	44%	6%	2%	....
Japanese-American Non-Hangings	8	21	16	31	6	3	85
Percentage	9%	25%	19%	36%	7%	4%	....

TABLE 4.—Japanese-American suicides in Honolulu: living situation, place of suicide, previous threats and attempts.

	LIVING SITUATION			PLACE OF SUICIDE			PREVIOUS THREATS AND ATTEMPTS			TOTAL
	Family	Institute	Self	Home	Neighbor- hood	Communi- ty	No Threats	Threats	1-2	
Japanese-American Hangings	62	16	6	67	2	15	41	28	15	84
Percentage	74%	19%	7%	80%	2%	18%	49%	33%	18%	....
Japanese-American Non-Hangings	63	14	8	49	1	35	50	25	10	85
Percentage	74%	17%	9%	58%	1%	41%	59%	29%	12%	....

living at home who expressed a cry for help through suicidal threats or attempts. Thus, there may be a case for a suicide prevention effort focused on public education for such groups. However, Mamoru Iga, professor of sociology at San Fernando Valley State College, explains the predicament of the life style among Japanese, particularly older persons. He states:

Traditional Japanese religions do not teach the importance of universalistic values, such as God as an absolute and abstract ideal which guides our development, or humanistic emphasis on the importance of developing our potential, especially intellectual one; they primarily teach people to adjust to existing social relations and find happiness within that context. Consequently, the main concern for their happiness becomes to get favorable responses from others, producing a lack of self-sufficiency. The lack of favorable responses or the loss of a sense of "belonging" means the loss of entire significance of life. To many old Japanese the objects of their meaningful communication have been mostly lost, and together with it they lost the will to live and also the capability to cope with frustration. Their incapability to cope with frustration is also a result of the lack of universalistic values in their social environments. Because of the lack of absolute ideals (such as God's teaching or humanistic love of fellow men), Japanese tend to be indifferent of other people in need of help. On the other hand, Japanese people are very eager to be associated with prestigious figures.⁴

Iga poses a double bind situation for older Japanese. Concentrating on social relations, an older Japanese person may become progressively depressed over loss of spouse and friends. At the same time, with the severing of significant relationships, there is loss of the will to live and seeming indifference to any response to the cry for help from others. Thus, the older person may feel trapped and unwanted.

An examination of older Japanese suicides reveals Iga's observations on loss of meaningful relationships and communication. For example, Mr. M. was a 71-year-old Japanese man who lived with his son, daughter-in-law, and grandchildren. He was born in Japan, came to Hawaii as a young man, and was now retired. About ten years ago, his wife died. Since his return from a trip to Japan, within a few months Mr. M. was unable to sleep and stayed up due to his insomnia. Moreover, he was alone during the day since the rest of the family was either at work or school. One day, his son found him dead of chemical poisoning after returning from work. His suicide note said: "I am sorry for having worried you so and having been a burden. Please forgive me." Recalling his previous behavior, Mr. M.'s son remembered that his father usually washed clothes for the family on Monday (the day he took his life) but had washed on Sunday. It was the first time that he changed his habit.

Edwin S. Shneidman in his article, "Classifications of Suicidal Phenomena,"⁵ views three types of suicide: (1) *egotic suicide*, where self-imposed death is the result of an intrapsychic struggle or dialogue within the self; (2) *dyadic suicide*, where there is social conflict with a significant other who is an important dyad in the victim's life; and (3) *ageneratic suicide*, where the individual has lost his sense of membership in the generations of the human race. In Japanese family structure there is the tradition of *in kiyo* ("hidden living" or "behind the show"). The generation process refers to: (1) the positive feature of freedom and privilege of retirement which releases an older Japanese person from the responsibilities of vocation and family; and (2) the often negative reality of loss and transference of authority and power to the son. Thus, for some persons, "hidden living" may involve a significant loss of generativity and wisdom to the extent that ageneratic suicide is the inevitable solution. Citing the changing attitude of the Japanese family system regarding the aged, Takashi Koyama observes the loss of support and security. He said: "In the old family system in which family members of succeeding generations lived under one roof, older members were respected and as they advanced in age, they were regarded as happy symbols of the prosperity of the family. In many cases they occupied the position of patriarch and his wife. In these modern times, the position of the patriarch and his authority have been lost. The survival of the traditional pattern and economic constraints are the only forces which now check the trend toward the nuclear fission of the family."⁶ Thus, further research should concentrate on an investigation of *in kiyo* and suicide among older Japanese.

NARCISSISM

Regarding the causes of suicide, over half of the Japanese suicides were under the care of a physician within the last six months prior to the suicide. Nearly one-fourth of both groups left suicide notes which reflected interpersonal turmoil, elaborations on physical illness, directions regarding personal property and debts, and a plea for forgiveness. Only two notes contained traces of psychotic ideation. The non-hanging group revealed social interpersonal conflicts, particularly marital and parent-teenager problems (30%) along with mental illness (36%) and physical illness (26%). However, physical illness (43%) and mental illness (36%) were prominent among the hanging group (Table 5).

Among older Japanese when social values or interpersonal relationships are no longer satisfactory, there is a turning into narcissism or preoccupation with bodily needs. As George A. DeVos

TABLE 5.—*Japanese-American suicides in Honolulu: physician care, suicide note, cause of suicide.*

	PHYSICIAN CARE WITHIN LAST 6 MONTHS		SUICIDE NOTE		CAUSE OF SUICIDE				TOTAL
	Yes	No	Yes	No	Physical Illness	Mental Illness	Economic	Social Interpersonal	
Japanese-American Hangings	48	36	20	64	36	30	8	10	84
Percentage	57%	43%	24%	76%	43%	36%	9%	12%	....
Japanese-American Non-Hangings	46	39	19	66	22	31	7	25	85
Percentage	54%	46%	22%	78%	26%	36%	8%	30%	....

points out: "In Japan widespread evidence of concern with health and illness suggests a considerable amount of hypochondriacal narcissistic preoccupation with the body at all ages. Psychiatrically, hypochondriasis is usually considered a symptom of excessive narcissistic libinal cathexis. It is not, therefore, surprising to find prevalent suicide over either illness or the physical depletion due to age."⁷ Thus, older Japanese need to adopt moral and religious values as well as meaningful communication with other persons in order to sustain themselves.

CONCLUSION

A preliminary study of Japanese suicide in Honolulu raises a number of questions. From a cross-cultural standpoint, the meaning of suicide to people of various cultures may take different shapes and forms. For example, S. I. Hayakawa in an article, "Suicide As a Communicative Act,"⁸ raises the issue of cultural bias regarding suicide. Whereas in the United States we deplore suicide, suicide has traditionally been regarded as an honorable path for a Japanese samurai or commoner to take under certain circumstances. For pitiable cases involving poverty, despair aggravated by illness, economic stress and lovers' suicide, there is sympathy and understanding on the part of the general public. Military suicide from a sense of duty and honor was admired. Moreover, death is seen not as a cessation of life but as a part of the entire life-process.

Hayakawa forces us to rethink our Western view regarding the morality or immorality of suicide. He also raises the problem of cultural bias to the extent that we should re-examine the mean-

ing of suicide as a communicative act within a particular culture. Moreover, what about the Japanese of Hawaii, who belong to a unique mixture of race and culture, with the interaction of three generations? How do Japanese suicidal patterns in Honolulu compare to those of other major cities such as Los Angeles, Seattle, and Tokyo? How do Japanese suicidal deaths compare to Japanese suicidal attempts in terms of lethal intent, degree of depression, and attitudes toward death?

Cross-cultural psychiatry offers a fascinating opportunity to explore the relationship between ethnicity and various aspects of mental health in a multi-racial community. In terms of cross-cultural research in suicidology, the Japanese of Hawaii have unique ethnological traits related to suicide method, life style, and narcissism in comparison to other racial groups. However, there is a need for further research to explore suicide attempts, depression, and attitudes toward death from an ethnic psychiatric perspective.

ACKNOWLEDGMENT

I wish to express my appreciation to Norman L. Farberow, Ph.D., and Robert S. Litman, M.D., Co-Directors of the Los Angeles Suicide Prevention Center who taught me the field of suicidology during my internship at the L.A.S.P.C. in 1965-1966; to John F. McDermott, Jr., M.D., Professor of Psychiatry, University of Hawaii School of Medicine, for his interest and encouragement in this study; and to George F. Schnack, M.D., Chairman of the Post-Session American Psychiatric Association, Honolulu, Hawaii, May 15-21, 1970, who invited me to present this paper for the Depression and Suicide Seminar.

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There's one chance in six that a solitary cold thyroid nodule is malignant—or one in three if the patient is Oriental or Hawaiian.

Malignancy in Solitary Nonfunctioning Thyroid Nodules

Report of 45 Cases

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Prediction of malignancy in solitary thyroid nodules on the basis of thyroid scan was completely unsuccessful. One-third of those excised from Oriental or part-Hawaiian patients proved to be malignant, and none of those from Caucasian patients, in this series of 45 cases.

THE SOLITARY thyroid nodule has been a subject of interest in the medical literature for many years. This interest has been related to the rather high positive correlation between this particular type of nodule and thyroid malignancy. A typical series of cases is one reported by Meadows¹ in 1962 when he found that between 10% and 33% of solitary, palpable thyroid nodules were malignant.

There have been attempts to distinguish the benign from the malignant nodule without resorting to open biopsy or surgical removal, in order to avoid what might be an unnecessary operation. One method has been the thyroid scan. It has been stated in many studies that the solitary "cold" nodule has a higher incidence of malignancy than other forms of thyroid nodules.

However, as pointed out by Andrews,² there are factors which may make it difficult to distinguish a nonfunctioning nodule from a hypofunctioning or normally functioning nodule. These factors include the size of the nodule, the location of the nodule in the thyroid gland, and the degree to

which the thyroid tissue located to the side of or behind the nodule functions. In one series of patients studied by Shimaoka and Sokal³ there was little significant difference found in the incidence of malignancy between "cool" or hypofunctioning nodules and "cold" or nonfunctioning nodules. Their conclusion was that other means should be employed to aid in separating benign from malignant nodules, since the majority of the smaller nodules were hypofunctioning and the larger benign and malignant nodules were nonfunctioning.

More recently a five-year study was reported by Kendall and Condan⁴ comparing the reliability of physical characteristics of the nodules to palpation and the degree of function on scanning as indicators of malignancy in these solitary thyroid lesions. It was their finding that the malignant nodules were functioning in 14% of the cases, were hypofunctioning in 50%, and were nonfunctioning in 36% of the cases. In contrast, the benign thyroid nodules were functioning in 5% of the cases, hypofunctioning in 28%, and nonfunctioning in 67% of the cases. Their conclusion from this study was that thyroid scanning is not a reliable method for determining which patients have malignant disease of the thyroid and therefore, on this basis, all solitary nodules should be excised.

The response of nodule to thyroid suppression is probably a more reliable test. If a nodule is reducible by thyroid suppressive therapy, then it is likely to be benign. On the other hand, if a nodule is nonreducible the risk of malignancy is greater.

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The primary purpose of this study was to determine the pathology found in solitary cold thyroid nodules in the group of patients studied and to look for any ethnic differences. Another purpose of the study was to evaluate the correlation between clinical preoperative evaluation, including thyroid scanning, and the pathologic diagnosis.

METHOD

A review was made of the thyroid evaluation records maintained in the Nuclear Medicine Department at The Queen's Medical Center of all patients who had undergone a complete preoperative clinical thyroid evaluation and had had a thyroid scan of satisfactory technical quality showing a solitary, nonfunctioning ("cold") thyroid nodule. To be included in the study, the patient had to have thyroid surgery and the pathology report had to be available. There were 55 such patients during the five-year period from 1966 to 1971. The group consisted of 23 Caucasians, 18 Orientals, seven Hawaiian-Orientals and seven Hawaiian-Caucasians. There were 42 women and 13 men, which reflects the usual female predominance of most thyroid studies.

The thyroid scans were reviewed separately without any identification. The palpable characteristics of the nodule could not be correlated with the pathological reports, since the physical findings were variably described with no common nomenclature. A specific attempt was made, however, to correlate the association of a solitary thyroid nodule in an otherwise normal appearing thyroid gland with malignancy, and to contrast this to the relationship between malignancy and a distorted, enlarged, or unevenly functioning gland.

RESULTS

Of the 55 cases studied, 46 had a benign nodule. Of these, 23 had a follicular adenoma, 16 a multiple colloid adenomatous goiter, two a simple cyst, three Hashimoto's thyroiditis, one subacute thyroiditis, and one focal fibrosis.

Of the nine patients who had malignancy, there were four with a mixed papillary-follicular adenocarcinoma, three with a papillary adenocarcinoma, one with a follicular adenocarcinoma, and one with a Hürthle cell tumor with malignant change. Interestingly, none of the nine patients with malignancy had other pathology described in the thyroid gland, other than the case of the Hürthle cell tumor.

Of the 23 patients with a follicular adenoma, nine had cystic degeneration of the adenoma and four had hemorrhage into the adenoma. All of the patients in the study were functionally euthyroid.

There were no specific age groups in which a thyroid nodule was more likely to be malignant other than the two malignant cases out of three nodules in the under 20 year group (Table 1).

TABLE 1.—Occurrence of malignant nodules by age.

AGE IN YEARS	TOTAL CASES	MALIGNANT NODULES
11-20	3	2
21-30	14	0
31-40	10	3
41-50	10	1
51-60	9	0
61-70	8	3
71-80	1	0

There was also no tendency noted for members of one racial extraction to be represented by only one sex or age group.

There were about three times as many malignant nodules in women as in men, the same overall sex ratios as that of the patients in the study (Table 2).

TABLE 2.—Occurrence of malignant nodules by sex.

SEX	TOTAL CASES	MALIGNANT NODULES
Female	42	7
Male	13	2

Attempts to predict which nodules were malignant were unsuccessful. Table 3 represents a comparison of the predictions made on the basis of the preoperative information available, including the appearance of thyroid scan, and demonstrates virtually random distribution of the thyroid malignancies. Retrospective viewing of the scans after knowing the pathology of the nodules still revealed no characteristics which would have helped to select the malignant nodules.

TABLE 3.—Comparison of malignant nodules with predictions.

PREDICTION	TOTAL CASES	MALIGNANT NODULES
Probably malignant	14	3
Indeterminant	13	3
Probably benign	18	2
	45	8

Although the overall number of cases studied was relatively small, there were some interesting differences between the occurrence of malignancies and the racial extraction. These differences are shown in Table 4. The Caucasian group had a lower incidence of malignancy than the group of Oriental extraction (probability of less than 0.02 by chi square) and even a lower incidence than all three other groups combined (also a probability of less than 0.02). There was no significant difference between each of the other groups. There was no predilection of the Caucasians for any one benign condition and the Caucasian-to-Oriental ratio was constant for the various benign conditions studied.

TABLE 4.—Comparison of nodules by racial extraction.

RACE	TOTAL CASES	MALIGNANT NODULES
Oriental	18	6
Caucasian	23	0
Hawaiian-Oriental	7	1
Hawaiian-Caucasian	7	2

DISCUSSION

In 55 cases of solitary, nonfunctioning thyroid nodules studied where surgery was subsequently performed and the pathological reports were available, the thyroid nodule was malignant in nine of the patients, or 16%. There were three times as many women as men in the study, and the ratio of malignant nodules was also three to one, showing no sex predilection in the number of patients studied. Preoperative prediction of malignancy, using all clinical and laboratory studies currently available and in common use, was unsuccessful.

There was less frequent occurrence of malignant nodules in those individuals of Caucasian extraction than for the other ethnic groups studied. Since all individuals live in the same geographic area and probably have similar dietary habits, it is possible that hereditary factors may be at least partly responsible for this difference. It is difficult to tell if the findings represent a higher incidence of malignant nodules in the Oriental group or a higher incidence of benign nodules in the Caucasian group. Although the findings might be compared with population statistics for the island of Oahu, this method would produce unpredictable error due to possible selectivity in the referral of these patients.

The current accepted therapy for adenocarcinoma of the thyroid gland is surgical removal. In this series of cases, however, five patients out of six underwent surgery for benign lesions. Although there was no mortality, the morbidity and the expense must be considered. This proportion of malignancy in the solitary, nonfunctioning thyroid nodule is in keeping with other published studies. It may be argued with some justification that many of the benign nodules, particularly those with cystic degeneration and hemorrhage, should also be removed, and this would place the desirable operative results in a more acceptable range.

What is really needed is a better method to predict the pathological problem preoperatively and perhaps some method such as the one proposed by Thomas⁵ with the simultaneous use of radioiodine and radioselenomethionine will resolve part of the problem in the future.

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The nurse sleeps sweetly, hired to watch the sick,
Whom, snoring, she disturbs.

William Cowper, *The Task*, Bk. 1

No correlation was found between serum alpha 1-antitrypsin levels and pulmonary disorder in 76 patients and 152 matched controls.

Clinical Significance of α_1 -Antitrypsin Level— A Preliminary Evaluation among Japanese Men*

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An association between obstructive pulmonary disease and intermediate α_1 -antitrypsin deficiency was not detected by this study. While it may be that no such relationship exists among the Japanese, it was not felt that a conclusion could be reached on the basis of this small number of cases.

IN 1963, Laurell and Eriksson¹ described three patients with marked deficiency of serum α_1 -antitrypsin in whom severe emphysema developed at an early age. Further study by Eriksson² demonstrated that in patients with a marked deficiency of α_1 -antitrypsin, chronic obstructive lung disease was observed more often than in healthy subjects.

Alpha-1-antitrypsin is one of the major protease inhibitors of human serum and it accounts for about 90% of the total trypsin inhibitory capacity of serum.² Chymotrypsin,³ plasmin,⁴ thrombin,⁵ elastase,⁶ and proteolytic enzymes from human leukocytes⁶ are also inhibited by this protein. It is a main component of the α_1 -globulin fraction of serum demonstrated by electrophoresis on filter paper, cellulose acetate, or agar gel.

The development of a special starch-gel electrophoresis technique revealed various different phenotypes of α_1 -antitrypsin.^{7, 8, 9} Seventeen phenotypes have been observed up to the present. It has been suggested by family studies that the phenotypes could be explained by simple Mendelian inheritance,^{10, 11} and that the multiple codominant alleles may exist at a simple autosomal locus.^{12, 15} The genetic system of α_1 -antitrypsin was named Pi, and the following codominant alleles have been described:^{7, 8, 16, 17} Pi^F, Pi^I, Pi^M, Pi^P, Pi^S, Pi^V, Pi^W, Pi^X and Pi^Z. Two additional alleles, desig-

nated as Pi^E and Pi^G, were reported by Fagerhol, M. K. at the International Symposium on Proteolysis and Pulmonary Emphysema, January 4-6, 1971, Pasadena and Duarte, Calif. Symbols for alleles were given according to the electrophoretic migration rate of the corresponding allele products. The migration rate is medium in the α_1 -antitrypsin resulting from Pi^M. Pi^F and Pi^I proteins are faster than Pi^M protein, while the Pi^P, Pi^S, Pi^V, Pi^W, Pi^X and Pi^Z proteins are slower; Pi^Z protein is an especially slow migrating component.

Using immunochemical methods, previous studies^{9, 16} have suggested that the alleles Pi^P, Pi^S, Pi^W, and Pi^Z yield 25, 65, 70 and 15 per cent, respectively, of the serum α_1 -antitrypsin concentration associated with Pi^M. Therefore, individuals of phenotype ZZ have a severe deficiency of α_1 -antitrypsin and this phenotype was shown by Eriksson² to be associated with chronic obstructive pulmonary disease. Recently, Fagerhol and Hauge¹⁸ examined the Pi types in a series of patients and found that in chronic obstructive pulmonary disease patients, not only the Pi phenotypes ZZ, but also SS and SZ were more often observed than in healthy subjects.

Eriksson's descriptions² of clinical features of obstructive lung disease associated with severe α_1 -antitrypsin deficiency have been confirmed by many subsequent reports.^{14, 15, 19-25} These include an early age at onset, often in the third or fourth decade of life, a rapid course with prominent exertional dyspnea or productive cough, and equal involvement of both sexes. Diffuse loss of vasculature over the lower lung field is observed by chest radiographs. Radioisotope lung scans demonstrate a decrease in perfusion of the lower lung fields and relatively increased perfusion in the upper lung fields.²² Panlobular emphysema is found on pathological examination.

From the Kuakini Medical Research Institute and the Honolulu Heart Program, National Heart and Lung Institute.

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The serum α_1 -antitrypsin deficiency is inherited as an autosomal recessive trait and the family studies involving the α_1 -antitrypsin deficient probands have shown a trimodal distribution. Normal, intermediate and severely deficient levels have been thought to correspond with normal, heterozygous and homozygous subjects, respectively.

Serum levels of α_1 -antitrypsin have been measured chemically by the trypsin inhibitory capacity^{2, 26-28} and immunologically with the immunodiffusion technique.^{14, 22, 29, 30} The former measures the total antitrypsin activity of serum. On electrophoresis it is known that 90% of such activity migrates with the α_1 -globulins. The latter method quantitates the serum α_1 -antitrypsin protein by way of agar gel immunodiffusion in the presence of antiscrum against α_1 -antitrypsin.

The serum level of this protein can elevate in response to inflammation or tissue damage as it is one of acute phase reactants.³¹

The present study concerns the estimation of the serum α_1 -antitrypsin levels in a Japanese male population living in Honolulu. The distribution of α_1 -antitrypsin levels in this population was observed by means of a single radial immunodiffusion test. The prevalence of heterozygotes and homozygotes for the α_1 -antitrypsin deficiency gene and the significance of heterozygosity are discussed.

MATERIALS AND METHODS

This study was carried out on a group of Japanese men born between 1900 and 1919, who are residents of Oahu and who participated in the second examination of the Honolulu Heart Study.³² Approximately 7,500 such men were examined between 1967 and 1970 and frozen sera are on file for about three-quarters of them. The method of selecting subjects for serum storage at various times depended on the year of birth, on the last digit of the study number, or on the sequence in which the men appeared for examination. It was always independent of the presence or absence of acute illness or lung disease.

Three groups of sera were selected for this study. The first consisted of 76 subjects with chronic obstructive lung disease who had a one-second forced expiratory volume (FEV_1) which was 55% or less of their functional vital capacity (FVC) on the day the blood was drawn. All of these men were also known to have had an abnormal spirogram two years earlier, at the first Honolulu Heart Study examination. Men with a history of tuberculosis or chest surgery were excluded. The second group consisted of 152 matched controls. These men had a FVC of at least 2.0 liters, with an FEV_1/FEC ratio of 70%

or greater and with no history of tuberculosis or chest surgery. Two controls were matched as closely as possible to each case with respect to age and cigarette habit. An attempt was also made to match according to the presence or absence of chronic cough and sputum production, but in some cases it was not possible. The third group of 197 "random" controls was selected in blind fashion from the remaining stored sera. Care was taken that each storage box was represented in choosing this group.

The serum α_1 -antitrypsin levels were measured without knowledge of the pulmonary status of the subjects from whom the serum specimens were obtained. The determinations were done by a single radial immunodiffusion technique using PartigenTM Immunodiffusion Plates (Batch No. 1028) and PartigenTM Standardized and Stabilized Human Serum (Batch No. 469) obtained from Behring Diagnostics, Inc., Woodbury, New York. The plates contain a layer of agar gel into which an antiserum to α_1 -antitrypsin has been incorporated. The agar layer contains twelve uniform cylindrical wells arranged around a central moisture chamber. This chamber contains a sponge which is kept saturated with water. According to the manufacturer's direction, PartigenTM standard human serum was diluted 1:7, 1:3 and 1:2 by saline yielding 19.3, 45.0 and 67.5 mg/100 ml, respectively. Sera under test were diluted 1:7 by using Biopette automatic pipettes (Schwarz/Mann, Orangeburg, New York). The wells were filled with 2 μ l of diluted standards or sera under test by using a Hamilton microliter syringe with repeating dispenser (Hamilton Company, Whittier, California). Three dilutions of the standard solution were examined on each plate. After incubation for 48 hours at room temperature, the diameter of precipitating rings were measured by a magnifying glass with 0.005 inch graduations (Flubacher & Co., Horgen, Switzerland). By plotting standard curves on semilog graph paper, levels of α_1 -antitrypsin in tested sera were analyzed. When low values were obtained, duplications were performed with non-diluted sera.

RESULTS

The diameter (inches) of precipitin rings of control sera differed slightly from plate to plate. For the 1:7 dilution, they ranged from 0.205 to 0.225, for 1:3 from 0.295 to 0.305, and for 1:2 from 0.345 to 0.360. Standard curves were therefore plotted separately for each plate.

The effect of serum storage on the results were investigated in two ways. A simple regression of the α_1 -antitrypsin level on the duration of storage showed a small but significant (P less than .01)

tendency for the level to rise with time. The equation was:

$$\text{Alpha-1-antitrypsin (mg/100 ml)} = 209.4 + 0.886 (\text{number of months in storage})$$

The correlation coefficient between these variable was 0.148.

In addition to the regression analysis, 26 subjects were retested using fresh serum. The mean (± 1 standard deviation) for the α_1 -antitrypsin level for these men on their stored frozen sera was 221.0 ± 81.8 mg/100 ml. The mean for the fresh sera was 218.1 ± 57.1 mg/100 ml. These results are not significantly different. The correlation coefficient between the original determination and the repeated value on fresh serum was 0.46.

Twenty-five of these 26 fresh sera were then stored in a frozen state for 1 month and again retested. The values after storage increased from 219.1 ± 58.0 to 228.5 ± 51.4 , which is not a significant change. The correlation coefficient after only one month of storage was 0.50.

Selected parameters are contrasted for the cases and matched controls in Table 1. The two groups are noted to be quite similar in age, smoking habit, and height. The cases have a much lower mean FEV₁ and FEV₁/FVC ratio. Their weight is also lower: Presumably that is because of their respiratory disease.

TABLE 1.—Comparison of selected characteristics between the chronic obstructive lung disease cases and their matched controls.*

CHARACTERISTICS	CASES	MATCHED CONTROLS
No. of subjects	76	152
Age (Yrs.)	60.1	59.5
FEV ₁ /FVC (%)	47.6 \pm 0.7	78.2 \pm 0.5
FVC (L)	2.8 \pm 0.9	3.0 \pm 0.4
FEV ₁ (L)	1.4 \pm 0.5	2.3 \pm 0.3
Height (in.)	63.7 \pm 0.2	63.6 \pm 0.2
Weight (lb.)	128.5 \pm 2.5	136.0 \pm 1.6
Proportion of group:		
who smoke (%)	54	53
with chronic productive cough (%)	12	6

* Mean \pm Standard Error.

The random controls were chosen in order to get a group of determinations which would be representative of the Honolulu Heart Study cohort without reference to lung disease, smoking habit, or respiratory symptoms. Mean values for relevant parameters are shown in Table 2, and compared to the values for the cohort. They are quite similar though the control group smokes a little more and has a slightly lower FEV₁/FVC ratio than the total cohort.

TABLE 2.—Comparison of selected characteristics of the random control group and of the Honolulu heart program cohort.*

CHARACTERISTICS	RANDOM CONTROLS	HONOLULU HEART PROGRAM COHORT
No. of subjects	197	7,498
Age (Yrs.)	55.6	56.4
FEV ₁ /FVC (%)	75.6 \pm 0.6	76.9 \pm 0.1
FVC (L)	3.14 \pm 0.04	3.12 \pm 0.01
FEV ₁ (L)	2.38 \pm 0.03	2.40 \pm 0.01
Height (in.)	64.4 \pm 0.2	64.3 \pm 0.03
Weight (lb.)	138.8 \pm 1.5	139.5 \pm 0.2
With chronic productive cough (%)	1	1
Proportion of group: who smoke (%)	43	40

* Mean \pm Standard Error.

The serum α_1 -antitrypsin levels obtained by age group are shown in Table 3. The overall means are 243.9 for the cases, 230.7 for the matched controls, and 218.0 for the random group. The value for the random controls (group III) closely approximates the 212 mg/100 ml reported by Kueppers.²⁹ Using a t-test adjusted for multiple comparisons,³³ no statistically significant difference was observed between the group with obstructive pulmonary disorders and the controls matched by age and cigarette habit. However, the mean value for the random group was lower than for the cases. No consistent relationship to age was found in any of the groups.

Of 76 cases with obstructive pulmonary disease in group I, one showed a markedly depressed α_1 -

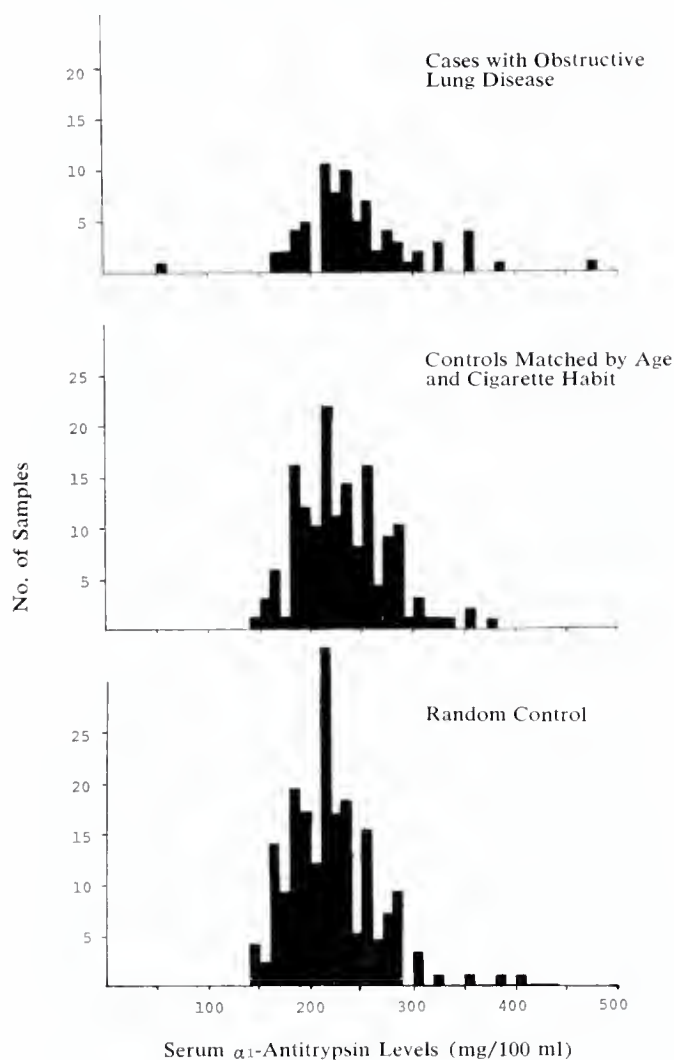
TABLE 3.—Serum alpha-1 antitrypsin levels (mg/100 ml).*

AGE GROUPS		45-49	50-54	55-59	60-64	65-69	TOTAL
Cases with Obstructive Lung Disease	No.	5	11	17	20	23	76
	Mean	228.2	246.3	242.5	242.8	248.0	243.9
	S.D.	26.9	52.0	69.8	66.4	51.8	58.0
Controls Matched by Age and Cigarette Habit	No.	8	27	33	45	39	152
	Mean	238.0	241.1	232.1	220.4	232.8	230.7
	S.D.	21.2	41.8	36.1	42.6	47.0	41.7
Random Control	No.	19	81	44	36	17	197
	Mean	229.9	211.8	220.0	224.6	215.5	218.0
	S.D.	41.5	38.9	49.3	37.3	41.8	41.7

* mg/100 ml Mean \pm 1 S.D.

antitrypsin level (55 mg/100 ml) (Figs. 1 & 2). This is thought possibly to have been due to some problem with serum storage in this man since a repeat value on fresh serum was 189 mg/100 ml.

FIG. 1.—Distribution of serum α_1 -antitrypsin level in three groups.



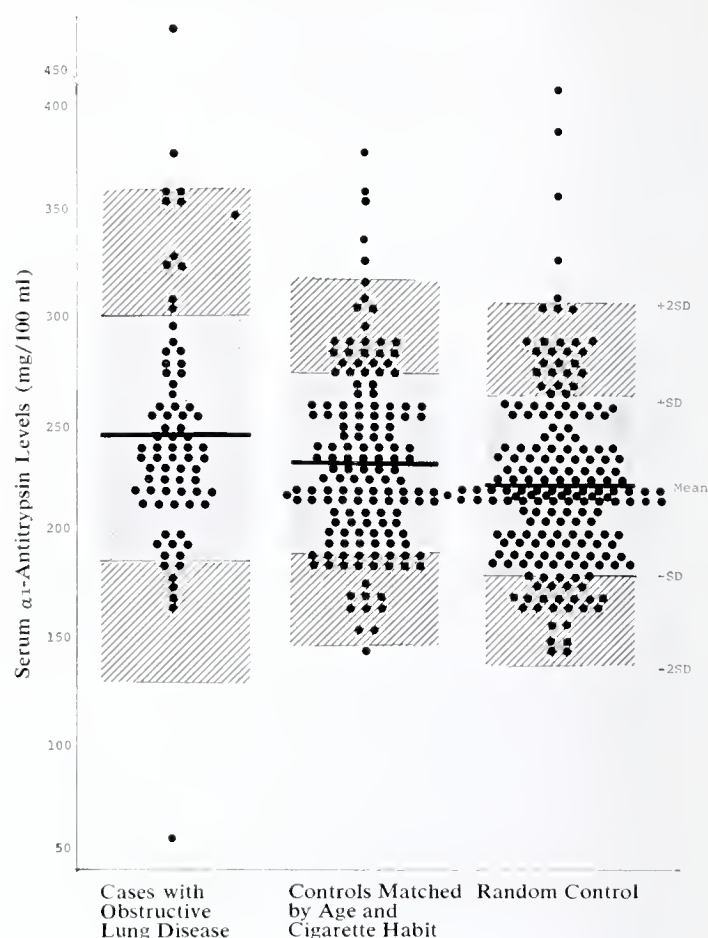
The distributions of the serum α_1 -antitrypsin levels do not appear trimodal (Fig. 1). No excuse of low or intermediate values for α_1 -antitrypsin is demonstrated among the pulmonary disease cases. In group III, 3.1, 6.1 and 10.4% of the subjects had α_1 -antitrypsin levels below 160, 165 and 170 mg/100 ml, respectively.

DISCUSSION

Although a high correlation has been observed between homozygous α_1 -antitrypsin deficiency and chronic obstructive lung disease, the significance of heterozygosity as a predisposing factor in the disease is still controversial.

Until recently only occasional reports of heterozygotes with the disease have been reported.^{2, 10, 23, 25} The studies of Eriksson² and Talamo et al,¹⁴ showed no remarkable occurrence

FIG. 2.—Distribution of numbers with different α_1 -antitrypsin levels.



of pulmonary disease among heterozygotes. However, Lieberman^{34, 35} demonstrated a higher than expected incidence of heterozygosity determined by the trypsin inhibitory capacity in patients with emphysema, and suggested that if heterozygous α_1 -antitrypsin deficiency is really associated with chronic obstructive lung disease, and if progression of lung disease can be prevented by avoidance of smoking and exposure to lung irritants, it could be an important aspect of a preventive medicine program to detect heterozygotes. As proteolytic enzymes are released by leukocytes and other macrophages in an inflammatory reaction, Lieberman stated, α_1 -antitrypsin deficient patients should avoid respiratory infections and should have them treated as quickly and adequately as possible. They should be firmly counseled against smoking and advised not to be employed by industries with exposure to irritating fumes, dusts or smog. The additional recommendation was made by Lieberman that a measurement of α_1 -antitrypsin as a part of the pre-employment examination in such industries would be valuable. It was also suggested as a premarital screening test. The measurement of the α_1 -globulin by electrophoresis of serum on cellulose acetate was introduced by him as a simple screening procedure for α_1 -antitrypsin deficiency.³⁶

Kueppers et al.³⁷ determined the phenotypes of serum α_1 -antitrypsin in a group of 103 patients with obstructive lung disease and found the frequency of heterozygotes in the patient group to be 25.5%. They concluded that heterozygosity may be a predisposing factor. In this study they compared the results of antigen-antibody crossed electrophoresis and serum α_1 -antitrypsin level measured by immunodiffusion technique. They pointed out that heterozygotes may not be distinguished from normal subjects if only quantitative criteria are used. The normal concentration found in some of the heterozygotes was explained by the possible coexistence of inflammation or pregnancy.

On the other hand, Welch et al.³⁰ suggest that intermediate α_1 -antitrypsin levels are not important in the causation of pulmonary disease. They found that 3 of 51 healthy persons and 17 of 146 consecutive patients with pulmonary disease had intermediate levels. These rates are not significantly different.

The present study did not demonstrate a higher prevalence of intermediate α_1 -antitrypsin levels among the patients with lung disease than among either of the control groups. There are several possible reasons for this. Although the patients had definite respiratory obstruction, there is no reason to believe that they all had pan-lobular emphysema. Presumably those with other causes for their outflow obstruction would not truly be at higher risk of having α_1 -antitrypsin deficiency than the controls. Although there is little doubt that marked emphysema was more common among the cases than the controls, it is probable that substantially fewer than 76 of these men had disease of the type previously reported to be associated with α_1 -antitrypsin deficiency.

Another factor which might obscure the detection of heterozygotes is their propensity to raise their levels of α_1 -antitrypsin in the presence of acute inflammation. However, since the subjects of this investigation had all been well enough to come in for a routine examination, it is unlikely that this was a major problem.

Lieberman and Talamo have suggested³⁶ that immunodiffusion is not as specific or as reliable for detecting heterozygotes as is the enzymatic assay. They pointed out some instances where an apparently normal level on immunodiffusion assay later turned out to be deficient when the trypsin inhibitory capacity was measured. Neither of these methods has been previously reported in a Japanese population. In the absence of either a trimodal distribution of values or well-defined family studies, it is not possible to clearly define the breaking points between normal levels and the

heterozygous and homozygous deficiency states. The distribution of Pi phenotypes has been reported to be significantly different in an Asian population.¹⁷ Thus, there is some reason to believe that the distribution of quantitative deficiency of α_1 -antitrypsin as well as its clinical significance will have to be re-evaluated in oriental groups.

The frequency of heterozygosity has been mostly reported around 5% using different methods in predominantly white populations,^{2, 30, 36} though more extreme values have been reported by Kueppers et al.^{12, 37} The prevalence among the Japanese is unknown and no clear definition emerged from the present study. A cumulative frequency distribution of our random control group showed that 3.1% of the subjects had levels less than 160 mg/100 ml, 6.1% were less than 165 mg/100 ml and 10.4% were less than 170 mg/100 ml. The mean value in the random group was significantly lower than the mean for the cases of obstructive lung disease. The reason for this is not clear.

Our experience using the single radial immunodiffusion technique on stored frozen sera suggests that there is a considerable amount of inherent variability. When the values obtained on 25 fresh specimens were repeated after one month of storage in a freezer, the correlation coefficient was only 0.50. The extent to which this variation is inherent in the methods and materials used in the determination, and the extent to which it may be introduced by freezing and storage is not clear at this time. It is possible that differences in the frequency of low values in the case and control groups may have been masked by this variability. A more definitive approach is needed in future studies. Actual Pi phenotyping would be desirable, but it is a more complex and expensive technique.

SUMMARY

Alpha-1-antitrypsin levels were measured on sera obtained from Japanese men 45 to 69 years of age who participated in the Honolulu Heart Study.

Stored sera from 425 subjects were chosen in three groups. Group I consisted of 76 subjects whose FEV₁/FVC ratio was measured at less than 55%. Group II was composed of 152 controls with normal spirograms, who were matched by age and cigarette habit against group I. Group III (197 sera) was chosen at random from the general population.

Mean (\pm 1 standard deviation) serum α_1 -antitrypsin levels were as follows: Group I, 243.9 \pm 58.0; Group II, 230.7 \pm 41.7; Group III, 218.0 \pm 41.7. The means did not differ significantly between the cases and the matched controls, but the mean for the general population was lower than for the cases.

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Thoughts on the Death of a Friend

*The thread of life which holds us all is, many times, too strong!
 Its bright resiliency can snap with sudden shock
 But when the pull of death is long
 The thread is stretched so fine and sharp
 That life and death cannot be told apart!*

*He lies motionless. Death has already struck
 But missed the first clean kill.
 Now—in a lonely place he waits—
 Suspended, body captive, away, barely animated, still—
 Until the thread of life is frayed so thin
 That what one thing does cause the final break
 No one can tell. . . .*

GEORGE BRACHER, M.D.



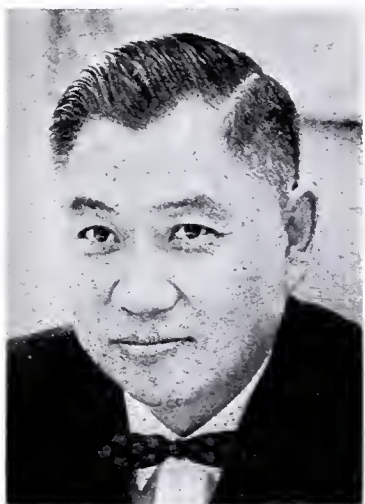
CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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...for every meal
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The President's Page

Milton Trager, M.D., who practices where the action is, would like to relay the following message:

According to our State Board of Health statistics, the number of reported cases of gonorrhea in 1971 was definitely—almost 25%—higher than that in 1970. The total figure represents only 20% of the actual number of cases suspected. It is an alarming fact that over half of the women who are infected are asymptomatic, and these form the greatest reservoir for the spread of this disease. If this “silent epidemic” is to be controlled, known contacts and the large pool of asymptomatic women must be treated. This means that physicians must question their patients for contacts, as well as identify asymptomatic cases, and report them to the Epidemiology Branch of the Board of Health. Names and addresses of the patients need not be given to the Health Department; initials will do unless the physicians prefer that the Health Department follow up the cases.

Important actions are being studied by competent committees. A blue-ribbon committee headed by George Mills and composed of Past Presidents John J. Lowrey, Theodore T. Tomita, B. A. Richardson, O. D. Pinkerton, and Samuel D. Allison, is reviewing the AMA Study of HMA with a view of recommending implementation, where feasible, to the House of Delegates.

The Bureau of Research and Planning, chaired by Dr. J. I. F. Reppun, is exploring the question of what part HMA should play in the cancer program in Hawaii. The officers and Council feel that HMA should remain involved in the clinical aspects of the cancer program.

An ad hoc committee composed of all six commissioners and chaired by Dr. Winfred Lee is in the process of redefining the committee structures of both the County and State with a view toward possible amalgamation or elimination of some of them.

Robert Y. H. Chin

AMA Delegate's Report

HAWAII MEDICAL JOURNAL

The 25th AMA Clinical Convention

At the 25th Clinical Convention in New Orleans, November 28–December 1, 1971, 10 reference committees met to discuss 20 reports from the Board of Trustees, 8 from the Council on Medical Service, 2 from the Council on Constitution and By-Laws, and one each from the Judicial Council and the Council on Long-Range Planning and Development, plus 72 resolutions.

The House of Delegates met for nine hours and forty-two minutes to deliberate over the reference committee reports and other issues.

The House of Delegates continued its quest for involving more young physicians in the decision-making process of the American Medical Association by developing a Section for interns and residents and a separate Section for medical students. This provided interns and residents for the first time with a voting voice in the AMA. The House also approved \$20 annual AMA dues for interns and residents. This may mean a modification of the ground rules for membership and dues for this group of doctors in the Hawaii Medical Association.

In his President's address, Dr. Hall again outlined his concerns regarding problems that confront organized medicine today. His request for an AMA constitutional convention did not pass.

The general consensus of the House of Delegates was that changes are occurring in the AMA, examples being voting rights for interns, residents, and medical students in the House, plus voting privileges for the Vice President in the Board of Trustees. It was also pointed out that the Council on Long-Range Planning and Development was continually reviewing the AMA structure and programs.

At the request of the Wisconsin delegation, open hearings for all of the membership will be held in June and November of 1972 to explore possible organizational changes in the AMA. The results of these hearings will be presented in a summary report in June 1973 in New York. The House of

Delegates also agreed that non-members of the AMA may participate in AMA scientific programs as "invited guests."

There were many reports and resolutions, and much testimony, regarding the physician's assistant. It was agreed that the AMA, through the Council on Health Manpower, should assume a leadership role in developing and sponsoring a national program for *certification* of the "assistant to the primary care physician." The Delegates also adopted a report from the Council on Medical Education, outlining essential requirements for AMA approval of educational programs for such assistants.

This issue has particular significance to the HMA since there are forces in the Hawaii State Legislature who are driving hard to establish ground rules for certification without optimum professional input. There are also requests for money to educate these physician assistants without an adequate study of their scope of responsibility. It is significant to note that the House of Delegates directed the Board of Trustees to develop guidelines for compensation of physicians for services of their assistants and report back to the House in June 1972.

The House also:

- ... directed the Board of Trustees and appropriate councils to study the cost of hospital services in consultation with the American Hospital Association.

- ... asked for immediate action by medical societies to improve the quality of emergency medical services.

- ... adopted a study by the task force committee on Community Health Care and on Community Health Delivery Systems. The report recommends that physicians should use all means at their disposal to ensure that all people are afforded equal access to adequate medical and health care and to support campaigns against drug abuse.

GEORGE H. MILLS, M.D.
AMA DELEGATE

Editorials

End Universal Smallpox Vaccination!

The United States is free from smallpox (we have not had a documented case of it since 1949) because of our nationwide practice of almost universal vaccination against it. Right? Wrong!

Our freedom from smallpox is attributable mostly to the steady decline of smallpox throughout the world. In 1960, the statistical chance of importation of a case of smallpox into the U.S. was about one case every 2½ years. In 1970, it had fallen to one case every 12 years, and it is still dropping.

Still, smallpox vaccination is a pretty harmless affair, a small price to pay for the added security it affords. Right? Wrong again!

Among just over 5 million primary vaccinations in the U.S. in 1968, there were 16 cases of post-vaccinial encephalitis, with 4 deaths; 5 cases of vaccinia necrosum, with 2 deaths; 58 cases of eczema vaccinatum, and 131 cases of generalized vaccinia. Less than 9 million revaccinations produced 6 cases of vaccinia necrosum, with 2 deaths, 8 cases of eczema vaccinatum, and 10 cases of generalized vaccinia. Sixty cases of eczema vac-

cinatum, with one death, occurred among contacts of vaccinated persons.

The risk of vaccination as it is now practiced is known: 7 to 9 deaths a year, and a few hundred cases of encephalitis, vaccinia necrosum, eczema vaccinatum, and generalized vaccinia.

The risk of importation of smallpox is extremely small, and getting smaller. England's abandonment of compulsory vaccination nearly 20 years ago has led to no epidemics there, despite the lowest population immunity level in Europe.

The recommendation of the U.S. Public Health Service, endorsed by the American Academy of Pediatrics, is that vaccination of all health service personnel, and all persons travelling to and from continents where smallpox still exists, should be continued—except for those persons with eczema (or a relative in the household with eczema), pregnant women, or persons with depressed immune mechanisms.

Compulsory routine smallpox vaccination is dangerous and unnecessary; it does far more harm than good; it should be abandoned.

Continue Routine Smallpox Vaccination!

The fact that America has had no smallpox epidemics in the past few decades is not merely due to luck; we could have predicted confidently that we would have none, because compulsory routine smallpox vaccination has prevented the accumulation of susceptible persons.

If routine vaccination is abandoned, except for travellers and health care personnel, we will accumulate a steadily growing reservoir of non-immune individuals, among whom smallpox could—if introduced—spread rapidly.

It is justifiably argued that vaccination itself is not harmless: it causes considerable morbidity, and some mortality. But if these figures are examined more critically they seem less alarming. Nearly all the serious and fatal reactions to smallpox vaccine occur in infants under one year of age. Vaccination could, and should, be deferred until age 3 or 4 years. This would greatly reduce the morbidity and almost eliminate the mortality.

Closer attention ought to be paid, too, to the hazard of vaccinating pregnant women, and pa-

tients—or relatives of patients—with eczema. The immunologically incapacitated patient should also be identified and exempted.

It is true that the world's endemic centers of smallpox are relatively small and few today as compared with even a decade ago. But travel is much more widely engaged in today, and much swifter; and with travellers so numerous, the possibility of admitting an unvaccinated person returning from an endemic area is almost as great numerically today as it was in 1960, and probably far higher than it was in 1930.

Then, too, Hawaii is a portal of entry from the Asian continent and Indonesia, where smallpox still is prevalent. The recent terrible extension of cholera beyond its former bounds may well warn us against risking such extension for smallpox.

We should go very slowly, and weigh the disadvantages with great care, before deciding to eliminate routine compulsory smallpox vaccination of children entering school. It could lead to calamitous consequences!

HAWAII MEDICAL JOURNAL

5 November 1971

Harry L. Arnold, Jr., M.D.
Editor-in-Chief, Hawaii Medical Association
510 South Beretania Street
Honolulu, Hawaii 96813

Dear Sir:

I respectfully submit the following answer to Dr. J. I. Frederick Reppun's editorial in the September-October 1971 issue of the HAWAII MEDICAL JOURNAL. Most of the ambulance attendants of Hawaii, as well as the nation, are concerned about the quality of emergency and transfer service rendered to individual patients stricken with disease or injury. This letter is in answer of agreement with Dr. Reppun, but presenting the ambulance driver and attendant's version of a problem that has long plagued you, the physicians of Hawaii and the public.

Perhaps publication of my article will enable the physician to view the problem in a different perspective. I hope that the physicians will exert their opinions and ideas on the Association, to show their obvious concern and you in turn can exert pressure and influence on the political turtles, who unless receive a sharp slap in the face to wake them up to the problems at hand, will sit on their duffs until nothing is done, and the problem and possible solutions drowns itself in red tape. My interest is simply that when my medical education is complete, I dread the thought of seeing one of my patients in an emergency room with a vertebral injury only to find it aggravated by an unknowing ambulance crew who didn't take the time, or didn't realize the extent of injury through inexperience or training. Consideration for publication of my article will be appreciated. I remain,

Sincerely yours,

Paul E. Jones, Jr.
1050 Kinau Street, #1208
Honolulu, Hawaii 96814
(Physicians Ambulance Co.)

In the HAWAII MEDICAL JOURNAL of September-October 1971, Dr. J. I. Frederick Reppun brings to focus the growing problem of providing properly selected, trained and experienced paramedical

personnel and Physician's Assistants. Although I have been driving an ambulance for a little less than a year, it does not take one long to find complete agreement with Dr. Reppun's opinions and ideas. A number of my colleagues and myself share Dr. Reppun's and many other physicians' feelings concerning possible solutions to Hawaii's ambulance dilemma and shortage of doctors. The present ambulance system of Hawaii is far below standards set by the American Paramedical Institute (API), the AMA of ambulance organizations across America.

Several of the personnel presently working in ambulances should not be there. Personnel should be carefully screened to find weaknesses and shortcomings in their psychological makeup. When a woman is giving birth, or a patient is in cardiac distress, with complicating pulmonary edema, is not the time to discover an attendant, or driver, cannot emotionally handle the situation.

Presently, the ambulance attendants in Hawaii are paid a very nominal salary for the amount of responsibility they are entrusted with. Garbage collectors make almost twice as much. This is another reason for the sometimes poor selection of personnel. Fully qualified personnel go elsewhere for higher paying salaries. In a recent KHVH-TV poll the people of Hawaii gave garbage collection a higher priority than ambulance service. When the public places this sort of priority, then gentlemen, change has to come.

The training programs in Hawaii are just now starting to show the results the API has long been striving for. However, training is only half the job. This is where you, the physicians of Hawaii, come into the picture. By allowing personnel in training to attend on-the-job training at hospital emergency rooms and various specialty wards such as OB, orthopedic, as well as many others, you, the physician can help yourselves and your patients by saying, "Look, this is the proper way to perform CPR, to deliver an infant's head from the birth canal, to do an orthopedic lift," or countless other minor procedures that can and do make the difference between the patient's well being, further injury, or possibly even death. Also, there is a definite need for newer, more modern equipment. For an ambulance to have outdated equipment is

continued page 60

HAWAII MEDICAL ASSOCIATION

116th ANNUAL MEETING—MAY 9-13, 1972

Ilikai Hotel—Pacific Ballroom—Honolulu, Hawaii

Program Theme: Pathology As It Relates To Clinical Practice

Special Guest Speaker:

WESLEY W. HALL, M.D.

President, American Medical Association

GUEST FACULTY

Jay Bernstein, M.D.

Director, Dept. of Anatomic Pathology
William Beaumont Hospital
Royal Oaks, Michigan

Edward A. Gall, M.D.

Director of the Medical Center
University of Cincinnati
Cincinnati, Ohio

Harold Israel, M.D.

Clinical Professor of Medicine
Jefferson Medical College
Philadelphia, Pennsylvania

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Wichita Medical Center
Wichita, Kansas

Harry W. McFadden, Jr., M.D.

Professor and Chairman,
Dept. of Microbiology
University of Nebraska,
College of Medicine
Omaha, Nebraska

John W. Rebuck, M.D., Ph.D.

Chief,
Division of Laboratory Hematology
Henry Ford Hospital
Detroit, Michigan

William O. Russell, M.D.

Head,
Department of Anatomic Pathology
M. D. Anderson Hospital
and Tumor Institute
Texas Medical Center
Houston, Texas

FIRESIDE CHATS—Sponsored by the Hawaii Thoracic Society
Tuesday, May 9, 1972, 7:00-10:00 P.M.
(Discussion on selected topic.)

HOUSE OF DELEGATES MEETING

Tuesday, May 9, 1972, 1:00 P.M.

Ilikai Hotel

Thursday, May 11, 1972, 1:00 P.M.

Ilikai Hotel

ANNUAL SPORTS AND SOCIAL EVENTS

Skin Diving Tournament—April 22-23, 1972—Kalaupapa, Molokai

Tennis Tournament—April 30, 1972—Kam School and Beretania Courts

Bow & Arrow Hunting Tournament—May 5-7, 1972, Island of Hawaii

Deep Sea Fishing Tournament—May 7, 1972—Honolulu

Golf Tournament—May 12, 1972, Francis Brown Golf Club

Annual Woman's Auxiliary Luncheon—May 12, 1972

Annual HMA Banquet—May 12, 1972—Pacific Ballroom, Ilikai Hotel

Sportsmen's Night—May 13, 1972—Natsunoya Tea House

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

... I'm not sure how much is my squawking, and how much is coincidence, how much is more function by committees, and how much is better reporting, but something is improving. I have more than twice as many reports from twice as many committees as ever before. Good show!

... **Crippled Children** is considering asking to be dissolved, or to be absorbed into **Chronic Disease**, since all they have discussed in the past few years is feces, and this function is being taken over by **Fee Survey**. Good show, men. Maybe this is one committee we can do without.

... In the hopper is a proposed merger of **Diabetes**, **Heart** and **Chronic Illness and Aging** (and perhaps **Crippled Children**). Again, good show, men! Whenever one group of ten or fifteen men can possibly do the work, let's not have four groups.

... What I had not realized until now was that the committee structure is set up by the House of Delegates, and can't be changed without them. Let's change that this May. Let's give the power to reconstruct the committee structure to the President and/or the Council. Let's not leave this delicate, important work to an unwieldy body that meets only once a year.

... We sadly need to improve communication between committees. For some time now, the question of changing the requirements for smallpox vaccination has been under study by **Communicable Disease** and also by **Ad Hoc Committee on Smallpox Vaccination**. Wouldn't it be ridiculous if these two official bodies of HMA came out with two different recommendations?

... **Communicable Disease** continues to work on V.D., with some apparent progress. Are you men giving adequate V.D. exams (serology and cervical and urethral smears or cultures) on every teenager and young woman you examine. If not, WHY NOT?

... The **Ad Hoc Committee on Drug Abuse** is proposing that it drop the "AD HOC" and become a permanent committee of HMA. It has been an active committee, with plenty to do, and in view of the rising importance of this problem, this is probably wise.

... **Arrangements** is lining up a good program for May. One action is to eliminate a separate

"Sportsmen's Night," and have the Annual Banquet on Friday, handing out sports awards the same night.

... **Environmental Health** has been meeting weekly to discuss the many problems our many "instant ecologists" have been throwing at us. Still undecided is the question of whether the HMA should stick to the scientific and health aspects or involve itself in the aesthetic aspects of pollution control. What about surveying the membership of HMA to determine the feeling of the whole group? Certainly the committee is doing great work, and putting in a lot of time studying the many problems. Standards that are too high are unworkable and unrealistically costly. Standards that are too low endanger us all. An aroused population will enable some real changes to occur, but we need to participate and give some guidance to these changes.

... **Health Manpower and Legislative** have been working on the proposed licensure laws for Physician's Assistants. The public and the legislature are demanding a law, and a program. Are we ready to give it to them? There is still so much undecided about how much the PA's can really do to help.

... **Joint Public Relations** (a marriage between NEWS MEDIA and PUBLIC RELATIONS of HMA and PUBLIC RELATIONS of HCMS) has been making some progress, but is somewhat stymied over the question of what kind of image the HMA wants to project. Perhaps a good problem for the GOALS COMMITTEE I have proposed. Communications with the media are improving, slightly.

... **Medicine and Religion** is preparing a pamphlet to be entitled "In Case of Serious Illness," for distribution in hospitals' admitting rooms, and perhaps elsewhere.

... **Quackery** has been debating what to do about Chiropractic ads. Also, a local masseur ran an ad last June claiming to "cure" people by using lights. A letter has been written to the Attorney General.

... **Bureau of Research and Planning** and **Medical Education** are both studying the questions of what to do to implement the Payne Survey. How to improve the quality of your medical work.

Aloha.

JOHN BROWN, M.D.

Vitamin C Revisited

Scurvy, once the sailor's scourge, is now rarely seen in the United States, although occasional cases are still found from time to time in ghetto dwellers, chronic alcoholics, and freak diet addicts.

Recently vitamin C has been in the news again, due in large part to the wide publicity given to Dr. Linus Pauling's book, which extolled its prophylactic value against the common cold. Over-the-counter sales of vitamin C tablets boomed, while the pharmaceutical industry ground its teeth in frustration at being unable to cash in on this bonanza. Vitamin C, having been around a long time, is not patented and "no patent" means "not much profit," as no single drug company can corner the market.

In the last few months the initial enthusiasm has waned somewhat, following several controlled studies which indicated no discernible benefit from administration of large doses of vitamin C in the prevention or attenuation of colds.

Whenever this happens, people begin wondering whether high doses of vitamin C might conceivably have some other beneficial effect, apart from producing heartburn and diarrhea. Pathologist Dr. Constance Spittle thinks it might. Writing in *Lancet* (December 11, 1971) she states that coronary-prone individuals have lower vitamin C levels, and suggests that atherosclerosis is a long term (or negative balance) of vitamin C which permits cholesterol to build up in the arterial system.

Needling the Neurologist

The cold, aloof, always preoccupied neurologist enjoys an exalted position in the academic hierarchy of any medical center. He is easily identified by his clean white coat with invariably a large pin stuck in the lapel. This is used for testing sensation and possibly for other mysterious purposes beyond the comprehension of ordinary physicians. The same pin is used on a succession of patients, never being changed unless lost, stolen, or otherwise misplaced.

Because of the repeated use of the same pin on several different persons, it is quite possible that the neurologist acts as an unwitting vector for certain nosocomial infections, with hepatitis coming immediately to mind. Although we live in an era of virulent inflation, the cost of pins has remained relatively low. Perhaps our esteemed

neurological colleagues might consider discarding the used pin each time, and using a fresh one for each examination?

Notable and Quotable

The psychosocial problems of adolescents, particularly those of the current generation, concern us all. Guilty parents feel that somehow they have failed their children, while over the long term we realize with some trepidation and uneasiness that these same children are going to be running the country and all its institutions about twenty years hence.

A thought-provoking article about this problem (by Henry Brinton *Lancet*, November 20, 1971) makes for some very interesting reading and a few quotes follow:

"There is a good deal of competition for the title of Most Prevalent and Crippling Disease. If we include those which are sociomedical, the prize goes unquestionably to adolescent emotional disturbance, which is almost as socially destructive as it is ubiquitous. The word 'permissiveness' is used in two senses, which leads to confusion. On the one hand it may imply enlightenment, under which head we could include the abolition of hanging and flogging, as well as legislation on homosexual activities and abortion. On the other hand it can signify the belief that all experience, including hard drugs, is an end in itself, coupled with abandonment of belief in purpose and with the moral nihilism which has so deeply infected our generation. It is permissiveness in the latter sense which will destroy society unless a counter revolution is promptly and forcefully organized."

"Of course, there are many causes for the loss of faith, and so of a sense of purpose. Most obviously the scientific materialism of the 19th century is having a delayed and devastating impact just when it has ceased to be credible. The affluent society has opened up the possibility for mischief to those who, a few generations ago, would have been absorbed in the struggle for existence."

"The trouble is that without an inherited and instinctive belief in purpose, introversion can be fatal. Once one begins to doubt anything, one comes to doubt everything. The trouble with so much modern psychology is that it has raised introversion to the level of a religion. It is a tendency, a cult which has spread to society as a whole."

W. PHILIP JONES, M.D.

Hawaii Academy of Family Physicians

... A COMPLETE PHYSICAL THAT ISN'T

One of our esteemed colleagues said in print the other day that it really isn't necessary to have a complete physical examination annually.

This potshot at one of the cornerstones of modern American medicine apparently drew little public comment. Many Ob-Gyn men insist on six-monthly Pap smears and a once-over-lightly breast and genitalia on their women patients of child-bearing age and older. Pediatricians advise periodic infant and school health examinations and immunizations on the child until he has grown out of their purview. Large company employers sort of like to bring their top executives to heel annually by making them genuflect before the company doctor for the procto, and the various levels of government, our biggest employer, often require an annual—be it only chest x-ray, CBC, urinalysis and BP. The latest health fad is the computer physical, geared for hi-speed, lo-cost, and cold-heart.

Of passing interest is a recent project of the Hawaii State Senior Center: multiphasic screening of senior citizens. This offering, held once every two months, is for the “apparently well”; at their age, of course, 55 or over, these citizens can usually dig up a symptom or two. Near and far vision and tonometry, urinalysis, blood hemoglobin, audiometry, blood pressure, and basic tests for diabetes are done. The electrocardioanalyzer is applied sometimes. Then comes the “exit interview” with a public health nurse, which is primarily an educational benefit provided the tested citizen. That the multiphasic screen “in *no way* replaces the examination he would receive from his own private physician” is stressed to him. However, considering that the one done at the Center is “free,” while the private examination may cost from \$20 to \$200, or even more, and is more likely than not to be excluded from insurance coverage, it is somewhat doubtful that the senior (and sometimes forgetful) citizen will heed that warning.

There is a real danger in all of these somewhat superficial examinations, and particularly in the case of the last mentioned “multiphasic” variety.

Nothing can supersede the careful and patient taking of a detailed history by an experienced diagnostician whose indices of suspicion are easily aroused even by nuances in the patient's reply or answer! No physician's assistant (PA), no medical student or intern or resident, not even a well-trained astute public health nurse, and *certainly* no computerized questionnaire, can take the physician's place in this, the most essential part of a review examination. Inadequate parameters on this particular subject, ineptly phrased standardized questions that cannot allow for “yes, but . . .” answers, and particularly impersonal attitudes, too often can lead to false negative conclusions. The data gathered by someone else than the reviewer may well lead him astray.

“Doc, I've had a complete physical just recently” may reassure the patient. His newly gained sense of health security, however, may rest on false premises.

So . . . the answer to our colleague mentioned at the start is:

An annual review of systems thoroughly gone into between patient/parent and physician—particularly by a physician who has been acquainted with his patient and his family for years—ending with an objective physical and laboratory examination as indicated by the history, concluding with a session on what the patient needs to do to keep fit and healthy—or how best to manage an infirmity—is the very least, and often times the very best thing we physicians can offer the public in preventicare.

J. I. FREDERICK REPPUN, M.D.

The Hawaii Academy of General Practice has adopted the recommendation of the American Academy and will be known henceforth as the Hawaii Academy of Family Physicians (HAFP).

X-ray View Box

HAWAII MEDICAL JOURNAL

- This is a 50-year-old Japanese woman with known myelofibrosis for 4 years. Her chief complaint is of 3 months' history of recurrent cramps and pain in the lower abdomen.

- Physical examination showed hepatosplenomegaly. A mass was felt in the right lower

quadrant which was freely movable and nontender.

- Roentgenographic examination of the small bowel revealed a tumor of the terminal ileum.

- What is your diagnosis?

- Answer is below.



Although this lesion was thought to be malignant radiographically and also at surgery, the pathological report was extramedullary hematopoiesis in the terminal ileum. Extramedullary hematopoiesis usually presents itself in the fetal areas of blood production, such as the liver and spleen. It is very unusual in the terminal ileum.

Submitted by

SIDNEY B. W. WONG, M.D.
RADIOLOGICAL SOCIETY OF HAWAII

Synopsis of Pediatrics

By James G. Hughes, B.A., M.D., 3d Ed., 1,141 pp., \$14.50, Mosby, 1971.

A COMPENDIUM or "handbook" of Pediatrics. It is concise, quite complete and well organized. Information is readily obtained. It has many practical suggestions. It would make an excellent reference book for pediatric interns and residents, as well as pediatricians starting out in practice.

Transactions of the Seventh Princeton Conference on Cerebral Vascular Diseases

James F. Toole, Chairman, 258 pp., \$9.75, Grune & Stratton, 1971.

THE VOLUME'S most informative chapter probably was that on the Critique on the cooperative study of intracranial aneurysms and subarachnoid hemorrhage. The Critique by Dr. W. Eugene Stern and the formal discussion which followed by Dr. Herbert Locksley are excellent articles for those who have tried to wade through the multitude of data gathered by the study. For those interested in the subject some of the data may not be new, but all the information that is known about subarachnoid hemorrhage and aneurysm is summarized neatly.

All in all the book covered widely the subject of cerebral vascular diseases.

WILLIAM W. T. WON, M.D.

★Meniscus Lesions; Practical Problems of Clinical Diagnosis, Arthrography and Therapy

By Prof. Dr. P. Ricklin, Priv.-Doz. Dr. A. Ruttimann, and Priv.-Doz. Dr. M. S. Del Buono. (American translation by Karl H. Mueller, M.D.) 142 pp., illus., \$16.75, Grune & Stratton, 1971.

THIS monograph on meniscus lesions is based on 2,500 arthrographies and 600 operative cases.

Short chapters on anatomy and physiology of the knee joint, pathogenesis of meniscus lesions, clinical diagnosis, ligamentous and capsular pathology, routine x-ray examination of the knee, and a concluding discussion of disability evaluation are interesting, but the monograph's greatest value lies in its detailed chapter on arthrography. Over 200 exceptionally well produced arthrograms are shown, together with adjacent lines drawn depicting the normal followed by a systematic review of pathological lesions.

"Meniscus lesions" is highly recommended to all orthopedic surgeons and their residents as well as to that particular group of radiologists interested in arthrography. Those already utilizing this diagnostic tool will greatly enhance their accuracy of interpretation and those not yet convinced may have second thoughts as to its usefulness particularly in the symptomatic postmeniscectomy case and in that knee which presents with many more subjective complaints than objective findings. The sub-

★ means highly recommended.

ject matter is concisely presented and the illustrations and photographs are excellent; the book should be readily available to all those dealing with problems related to the knee.

CHARLES WM. BARNES, M.D.

★A Guide to Dermatohistopathology

By Hermann Pinkus, M.D., and Amir H. Mehregan, M.D., 546 pp., \$20.00, Appleton-Century-Crofts, 1969.

IF THERE had already been twice as many good English-language textbooks on the histopathology of skin diseases as there are, this one would still be an essential one for every physician with more than a superficial interest in the subject. No pathologist should be without it, even if skin pathology is only a part of his field of interest; and any dermatologist would profit greatly by reading it. Pinkus has described at least four new pathological entities and revived another, and his exciting kinetic view of skin carcinogenesis, recently given strong support through electron microscopy, should be read by every dermatologist and could be enjoyed by any physician. As Eric Fennel said of Maximov, "He mixes brains with his hematoxylin and indigocarmine."

HARRY L. ARNOLD, JR., M.D.

Osteoporosis

By Uriel Barzel, M.D., 290 pp., \$25.00, Grune & Stratton, New York, 1971.

THIS is the result of the first International Symposium on Osteoporosis held in New York City at the Montefiore Hospital and Medical Center, June 25, 1969. It consists of well-edited papers, presented at this symposium by men of diverse backgrounds, covering the broad scope of osteoporosis. There are 21 original papers (2 more were not published), all devoted to the subject, ranging from rather homey observations on Dowagers Hump to a very scholarly article on the regulation of bone cell function. I must assume it is scholarly, since at my clinical level of knowledge, it is absolutely unintelligible.

All in all, this book is a beautiful beginning and an excellent handbook for the experimenter and researcher in the field of osteoporosis.

From the clinical standpoint and from the standpoint of philosophy of treatment, there does not appear to have been much new in New York, June 1969.

This book is definitely *not* recommended for the average clinician interested in osteoporosis.

ROWLIN L. LICHTER, M.D.

Also Received

Uremia: Progress in Pathophysiology And Treatment

By John P. Merrill, M.D., and Constantine L. Hampers, M.D., 115 pp., \$7.00, Grune & Stratton, 1971.

A VERY thorough search of recent literature on uremia. A useful reference book for those interested in various aspects of uremia.

Life in These Parts

The enterprising nurses on Makai III decided to take advantage of the pervading festive friendliness and posted a large sign with the following inscription: "New Years Resolution: We will write more legiably." The following physician names were listed: "N. Oishi, D. Marnyama, G. Morimoto, D. Seto, I. Nadamoto, and F. Ikezaki..." Some smart alec physician had the last say, however, for he detected the misspelled "legiably" and had added, "and spell correctly."

Sportily dressed Al Paraz was proudly exhibiting his brand new 130-HP, 4-cylinder foreign-made sports coupe. "It's a Volvo" he explained, then added, "the boys over there at St. Francis (Hospital) tell me that it's like a woman..."

The October rains raised a serious mosquito problem on Kauai. Richard Cardines, district health officer, miffed by the multiple complaints and the lack of personnel and funds to cope with the problem, offered: "Kauai is a paradise for mosquitoes as well as for man. . . . There always will be a lot of mosquitoes because there are too many breeding places. . . . One answer would be to develop Kauai and pave the whole island, eliminating places where stagnant water collects."

When we mentioned in this column how our bow ties were becoming frayed and they were impossible to purchase in this day of changing fashions, Connie (Mrs. Hunky) Chun presented us with four beautifully hand-crafted bow ties. . . . We learned that she has been making them for all those bow tie adherents at St. Francis including Hunky, Gordon Lin, Walter Chang, Bob Mookini, Tom Frissell, and HQ Pang. . . . Connie, incidentally, has been supplying refreshments at our annual HMA Tennis Tournament for the past 2 years. . . . Now that we think about it, Hunky and his partner have been winning these tournaments rather consistently. . . . Oh no! she *couldn't* have been spiking those drinks. . . . Heaven forbid such thoughts. . . .

At a Kuakini executive committee meeting, a proposal to give voting status to ex-officio department heads of radiology, anesthesiology, and pathology was being debated. When Tom Fujiwara commented sympathetically, "It must be a frustrating experience, like the lack of orgasm, so to speak. . . ." The committee unanimously voted for the proposal. . . .

During the shipping strike and the resulting critical shortage of essential items here, Robert Moser attended a meeting of the AMA Council on Drugs in Chicago. During one all-day meeting, he slipped out to purchase 12 rolls of toilet paper which he gift wrapped for hand carry as per wife's instructions. . . . Word leaked out at AMA headquarters about the "strange cargo" and he was the butt of many jokes. . . . Upon return to Maui with his precious cargo, Bob clipped out a photograph of the barren supermarket shelves from the *Maui News* and sent several copies to some of the key scoffers at AMA with the note, "Don't laugh—just send TP!" John Ballin, director of AMA Department of Drugs, sent the following postscript: "Your urgent message has been received. I have today consulted the business manager of the AMA and have received permission from him to ship to you, from AMA's private stock, a generous helping of the

commodity you so urgently need. Don't say the AMA never did anything for you for your dues money!" The TP came airlifted. . . .

It seems that 27 of the 28 marlin caught at the last Kona Billfish Tournament were mercury contaminated above the Federally authorized level of five-tenths parts per million. Henri Minette, chief of Health Department laboratories, hastened to add that marlin is not a table fish and is not used for fishcake here.

Bill Davis, new director of a free vasectomy clinic, regards using pickle juice to kill sperms an extreme birth control measure. Bill points out that with vasectomies, "What we do is close the sperm factory leaving the hormone factory producing the same. We've stopped the baby-making function, but not the enjoyment factor." Bill can confidently reassure the patient because he's had the operation himself, "and I haven't gotten fat, my voice is not falsetto, my beard hasn't fallen out, and my sex life is the same, if not a lot better because of the psychological relief." He recommends vasectomy "over pickle juice, any day."

During a talk to the American Osteopathic Association meeting in Honolulu, our Editor Harry Arnold, Jr. recommended a bottle of meat tenderizer as a must for any first aid kit. "It's enormously effective in treating Portuguese man of war stings and most insect stings. . . . It's really a pearl. . . . When meat tenderizer is mixed with a little water and rubbed into a sting, the pain disappears within minutes and welts disappear within a short time." He also reported that exotic tropical skin disorders, except for leprosy, do not occur in Hawaii, that scarlet fever is notoriously mild here, that swimming pool granuloma occurs particularly on Maui where the infectious organism is acquired by swimming in irrigation ditches and open reservoirs, that insects and other arthropods are remarkably few and unobtrusive in Hawaii because of the *Bufo americanus* and man's eradication efforts, and that the wild bird mite, *Liponyssus bursa*, infests the common mynah bird and its nests and readily enters houses by being blown through the screens. It produces the only insect bite which itches most of the time for a full week before healing.

Fellow dermatologist Norman Goldstein reported at the same meeting that PreSun (PABA in ethyl alcohol) is 95 per cent effective as a sunburn protective in humans and that it prevents skin cancer in hairless lab mice. Norman is also using a Hawaiian seaworm extract, first investigated by Frank Tabrah et al, for treating skin cancer in hairless mice. . . .

Pediatric surgeon Walton Shim reported that cleft lip and cleft palate are twice as common among Japanese babies as in the general population, that pyloric stenosis occurs most frequently in haole infants and much less among Japanese, and is seemingly nonexistent among Chinese infants, and that club foot is commonest among pure Hawaiians. . . .

When Maui's Katsuyuki "K" Izumi married Edith Kashiwa over 32 years ago, they gave each other an orchid plant and started a garden which grew and grew until it covered an acre around their home in Wailuku. The Izumi garden is visited regularly by visitors from around the world and its trees and plants come from many parts of the world including India, Africa, Puerto

Rico, Hong Kong, Australia, Trinidad, Malaysia, the East Indies and England. . . .

Quotable Quotes

Akira Kutsunai: "Communication is intercourse in the broad sense of the word. . . ." (Overheard during a dialogue on the lack of communication between floor nurses and physicians).

Grant Stemmerman: "Another name for Norfolk Pine . . . Virgin pine. . . ."

Beer connoisseur **Phil Lee:** "There are two things I own and won't share . . . My Coor's beer and my wife."

Richard Suehiro from the School of Public Health was curious: "Does smoking impair libido?" Gynecologist **Noboru Ogami** answered matter of factly: "Well, I certainly won't recommend smoking during sexual intercourse. . . ."

George Suzuki's definition of a galloping gourmet: "A local Polack chasing a garbage truck."

"MEDICALLY SPEAKING"

The December 29 program was entitled, "All you wanted to know about sex but were afraid to ask" with panelists, Gynecologists **George Goto**, **Philip McNamee**, **Francis Terada** and **Alistair Philip**. A telephone caller asked, "Is there a safe period?" Dr. McNamee was quite explicit: "According to my practice, there is no safe period. . . . People who use the rhythm method are called 'parents'."

Professional Moves

1972, the Year of the Rat, is upon us. It is the beginning of a new era, a time of timidity and meanness, a time for good international relations and for bad marriages. . . . In fact, the Hong Kong astrologers say that the rat is a bad omen for connubial bliss . . . so be forewarned, ye nonbelievers. . . . But we are still catching up with a backlog of professional moves from the Year of the Boar.

In October, Maui pediatrician **Marion Hanlon** returned from a 3-year leave of absence during which he obtained a Master of Public Health degree from UC in maternal and child health, worked with a program for the mentally retarded, served as director of a Drug Abuse Counseling Center, and was clinical instructor in pediatrics at UC. Marion will head a new department of adolescent medicine at the Maui Medical Group. **Jose Chua-Chiaco**, who trained at Brooklyn Jewish Hospital and the Catholic medical centers of Brooklyn and Queens, joined the Maui Medical Service. Retired US Public Health Service medical officer **Russell Pierce** was named chief of the State Health Department's medical health service division. **Ivan Bird**, former assistant medical director of forensic psychiatry at the Trenton Psychiatric Hospital in New Jersey, was appointed to the Mental Health Team for Courts and Corrections. **Maurice J. Schluskel** became the new clinic director for the VA's Outpatient Clinic of the Regional Office.

In November, psychiatrist **John Pierson** joined the Honolulu Medical Group and general surgeon **William Kiyoto Morioka** joined the Central Medical Clinic. On Maui, psychiatrist **Dorothy Natsui La Fon** opened her office at the Maui Professional Center. Kauai acquired five new physicians. Ob-Gyn man **Patrick Aiu**, internist **Robert Caven** and surgeon **Wallace Greene** joined the Kauai Medical Group, while radiologist **Clarence Fnuaki** joined the Wilcox Hospital. **Lawrence van Loon** from Kalaupapa joined **Patrick Cockett** at Kapaa.

In December, **Robert C. Lee, Jr.** relocated to Suite 572 Alexander Young Bldg. and **Vernon Thompson**, counseling psychologist, associated with psychiatrist **Harry Hinson** at 1441 Kapiolani Blvd. At long last, Waimanalo got a private physician, yet another Manayan, a **Bienvenido Manayan**, (Henry and Cora's brother), who affiliated with the Fil-American Medical Associates and opened an office in Waimanalo. **Henry Minette** was named third deputy director in the State

Health Department, to administer all environmental health programs. Health Department Director **Walt Quisenberry** says hopefully, "The department will be able to work more aggressively and faster on environmental problems." **William Deering** became the institutions medical services director of the Medical and Hospital Branch of Waimano Training School and Hospital, and psychiatrist **Richard Presbrey** joined the Department of Health's mental health team for courts and corrections.

Tom Thorson's Corner

Amos and Andy Joke: "Amos, I got myself a subpoena. . . . What's a subpoena?" "Well, Andy, you have to go back to the Latin to understand. . . . You know what 'sub' means. . . ." "That's under." "Poena, you know what that is. . . . Now what's under the penis?" "The balls." "Exactly, so 'subpoena' means 'They got you by the balls'."

A neophyte to Alaska wanted to be known as a "sour-dough" and asked a grizzly Alaskan oldtimer how he could become one. "Well, you have to drink a gallon of whiskey, lay an Indian squaw, and kill a bear bare-handed. . . ." The newcomer, eager to please, forthwith downed a gallon of whiskey, staggered out and spied a bear which he chased into the woods. . . . There ensued a wild commotion, grunting and painful screams with fur flying. . . . Finally, there emerged a specter, half clawed to death, his clothes all tattered, but wearing a silly victory grin, muttering, "Now where is that Indian squaw you want me to kill. . . ."

Conference Humor

The inguinal node biopsy slides from the 16-year-old girl with metastatic malignancy had been circulated among the pathologists with opinions ranging from lymphoma to Ewing's to Burkett's to some hematopoietic neoplasm. **Takushi Hayashi** who does the electron-microscopy finally found a section of rhabdomyosarcoma after making over 80 slides. **Noboru Oishi**, who had been betting on lymphoma, teased: "Can it be two neoplasms?"

Grant Stemmerman: "Oh no, there is no doubt that it is embryonal-cell rhabdomyosarcoma, in retrospect."

Takushi, himself, was rather proud of the "desmosomes" he had demonstrated and gravely reported that "desmosomes," first reported in Japan, had never been demonstrated heretofore in the western hemisphere. . . .

Quint Uy: "Inferior equipment, eh?"

Takushi: "Good instrument . . . Good eye."

Grant was ecstatic: "This is a victory for electron microscopy. . . . This is probably the first time a diagnosis of embryonal cell rhabdomyosarcoma was ever made with electron microscopy. . . ."

A 46-year-old mason contractor with Ca of the lungs and brain metastasis had craniotomy 3 years ago, subsequent LUL lobectomy and radiation to both brain and lungs. **Grant Stemmerman:** "This is incredible. What is the quality of survival?" Neurosurgeon **Max Urata:** "He has hemianopsia, but is able to do odd jobs and play golf." **Ed Quinlan** added: "And golf takes skill." **Noboru Oishi** looked around at the golfers and questioned the validity of Ed's statement: "It doesn't take skill, does it?"

Elected, Appointed, Honored

On the county society fronts, the Honolulu County Medical Society elected **Winfred Lee** president to succeed **Tom Frissell**, who deserves a well earned rest. **Bill Dang** is president-elect, **Bill Moore, Jr.** the secretary, and **Al Chun-Hoon** the treasurer. New to the Board of Governors are **William Goebert**, **Reginald Ho**, **Andrew Morgan**, **Niall Sully**, and **H. Yokoyama**. The Maui County Society installed **Denis Fu** president, **John Withers** vice president, **Jose Romero** secretary-treasurer. The delegates are **A. Y. Wong** and **John Morris**.

The Hawaii Academy of Family Physicians elected

continued page 61

New Members



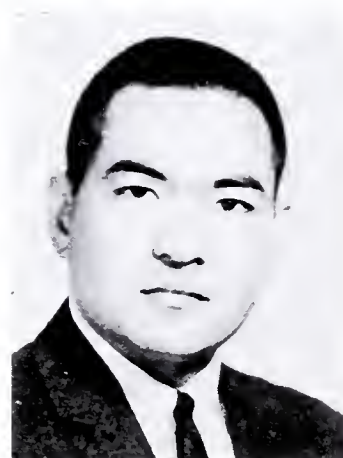
Edwin B. Adams, M.D.
1239 Wilder Avenue
Honolulu, Hawaii 96822
GENERAL PRACTICE
University of Vermont—1948
Internship—Queen's Hospital—
1948-1949
Residency—Veterans Administration,
Pittsburgh, Pa.—1960 (3 months)



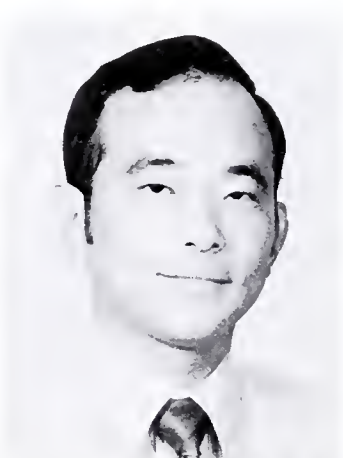
Fernando C. Atienza, M.D.
839 South Beretania Street
Honolulu, Hawaii 96813
PEDIATRICS
Far Eastern University,
Manila, Philippines—1962
Internship—Mt. Sinai Hospital,
Cleveland, Ohio—1962-1963
Residency—Mt. Sinai Hospital,
Cleveland, Ohio—1963-1964
Baltimore City Hospital—1964-1965
Hematology—Children's Hospital
Washington, D. C.—1965-1966
Babies & Children's Hospital,
Cleveland, Ohio—1966-1967



Samuel C. Gresham, M.D.
747 Amana Street
Honolulu, Hawaii 96814
INTERNAL MEDICINE &
CARDIOLOGY
University of Florida—1965
Internship—Union Memorial
Hospital, Baltimore, Maryland—
1965-1966
Residency—Union Memorial
Hospital, Baltimore, Maryland—
1966-1967
Queen's Medical Center—1968-1970
Queen's Medical Center—
Cardiopulmonary Fellow—1970-1971



William K. Morioka, M.D.
1481 South King Street
Honolulu, Hawaii 96814
GENERAL & THORACIC
SURGERY
Indiana University Medical School—
1963
Internship—Indiana University
Medical Center—1963-1964
Residency—St. Louis University
Group Hospitals—1964-1969



Richard Y. Mitsunaga, M.D.
850 Kam Highway
Pearl City, Hawaii 96782
PEDIATRICS
University of Michigan—1964
Internship—Midland Hospital—
1964-1965
Residency—Naval Hospital,
San Diego—1967-1969



Kosta Stojanovich, M.D.
888 South King Street
Honolulu, Hawaii 96813
PSYCHIATRY
University of Maryland—1963
Internship—St. Francis Hospital—
1963-1964
Residency—UCLA—1964-1967

HAWAII MEDICAL JOURNAL



Melvyn M. Kaneshiro, M.D.

1833 N. King Street
Honolulu, Hawaii 96819
INTERNAL MEDICINE
Tulane University School of
Medicine—1963
Internship—Charity Hospital,
New Orleans, La.—1963-1964
Residency—Charity Hospital,
New Orleans, La.—1964-1967



Thomas Y. Kobara, M.D.

1319 Punahou Street
Honolulu, Hawaii 96814
PATHOLOGY
Northwestern University—1966
Internship—Deaconers Hospital—
1966-1967
Residency—Deaconers Hospital—
1968-1970
St. Francis Hospital—1970-1971



Marinus Krijger, M.D.

North Shore Clinic
Kahuku, Hawaii 96731
GENERAL PRACTICE
Northwestern University—1965
Internship—Bethesda Lutheran
Hospital—1965-1966
Residency—General Hospital,
Ventura County—1969-1971



Ignacio A. Torres, M.D.

1300 Pali Highway
Honolulu, Hawaii 96813
**GENERAL & THORACIC
SURGERY**
College of Medicine,
University of the Philippines—1962
Internship—Youngstown Hospital,
Youngstown, Ohio—1963-1964
Residency—Honolulu Integrated
Surgical Residency Program—
1964-1968



Maxwell M. Urata, M.D.

1010 South King Street
Honolulu, Hawaii 96814
NEUROSURGERY
Washington University (St. Louis)—
1959
Internship—Indiana University
Medical Center—1959-1960
Residency—Indiana University
Medical Center—1960-1961
Indiana University Medical Center—
1963-1967



Sidney B. W. Wong, M.D.

888 South King Street
Honolulu, Hawaii 96813
RADIOLOGY
Northwestern Medical School—1964
Internship—Chicago Wesley
Memorial Hospital—1964-1965
Residency—Chicago Wesley
Memorial Hospital—1968-1971

County Society News

HAWAII MEDICAL JOURNAL

Hawaii

The annual dinner meeting was held at the Hilo Yacht Club on December 16, 1971. The business meeting after dinner was called to order by the Vice President, Dr. DeWitt Hendee Smith. Elections to office were then conducted with the following results:

President: Dr. DeWitt Hendee Smith
Vice President: Dr. Tadao Nagashima
Secretary: Dr. Edward Ballerini
Treasurer: Dr. Alan Takase
Delegate: Dr. Egbert Fell
Alternate Delegate: Dr. Peter Fleming
Medical Practice Committee: Dr. Keith Nesting and Dr. Thomas Mar

Several new members were voted into the Society. They were: Dr. Ruben Casile, Dr. Robert Lynn Moore, Dr. Marjorie K. Orr, Dr. Stanard Smith, Dr. Moon Park, and Dr. Ruth Matsuura.

Honolulu

The membership were introduced to new members: Drs. Edwin Adams, Fernando Atienza, Maxwell Urata, and Sidney Wong at the December 7 Annual Meeting and Election.

Dr. Frissell announced the rules for election. He stated that the polls would be closed at 8:15 P.M. instead of 8:00 because of the delay in getting started. He stated that the Secretary would cast the vote of the Society for the following unopposed offices: President-Elect, Secretary, Board of Censors, and Alternate Delegates to HMA. Dr. Frissell announced that tellers for the election would be Dr. Gabriel Ma, Chief Teller, and Drs. Michael Okihiro, Cesar DeJesus, Ichiro Nadamoto and Felix Lafferty.

Dr. Herbert Chinn announced that the Quality of Care Study initiated by the Hawaii Medical Association is now in its fourth phase which is the EMCRO phase. He stated that the cooperation of the physicians is needed in order to make this phase meaningful, and urged all physicians to respond favorably when asked to participate.

Dr. Frissell announced that the Society's dues for 1972 would be \$90. An increase of \$10 from the previous year.

It was announced that the 1971 annual reports of the Society were circulated in the mail. The annual reports were accepted as circulated.

Mrs. Richard K. B. Ho, president of the Woman's Auxiliary, presented a report of the Auxiliary's activities for 1971. She introduced newly installed president Mrs. Frederick Shepard who in turn introduced the rest of the Auxiliary officers for 1972. They were Mrs. Robert C. Lee, President-Elect; Mrs. Philip J. W. Lee, Vice President; Mrs. Max Botticelli, Recording Secretary; Mrs. Alan Pavel, Corresponding Secretary; and Mrs. Shigemi Sugiki, Treasurer.

On behalf of the Society, a lei and a plaque were presented to Dr. Frissell in recognition of his leadership as president of the Medical Society for 1971.

The results of the election were announced by Dr. Ma as follows:

President-Elect: William W. L. Dang
Secretary: William F. Moore, Jr.
Treasurer: Albert Chun-Hoon
Board of Governors: H. William Goebert, Reginald C. S. Ho, Andrew Morgan, Niall M. Scully, and Henry N. Yokoyama
Alternate Board of Governors: Roger B. Brault, Winfred Y. K. Chang, Henry T. Oyama, and Alan Pavel
Board of Censors: Thomas P. Frissell
Medical Practice Committee: Lawrence H. Gordon, John M. Ohtani, and Walter K. T. Shim
Nominating Committee: Glenn M. Kokame and Henry N. Yokoyama
Delegates to HMA: Anna Maria Brault, Clifford B. G. Chang, Edward Chesne, Charles T. H. Ching, Hing Hua Chun, William G. Davis (2 years), Robert Nordyke, Robert Oishi, Arthur K. Wong, and Henry N. Yokoyama
Alternate Delegates to HMA: Manuel Abundo, John F. Balfour, Catalino Cachero, Kenneth Chinn, David T. Eith, George Garis, Fred I. Gilbert, Jr., Lawrence H. Gordon, Meryl Haber, Victor Hay-Roe, Reginald C. S. Ho, Edward H. Izawa, Philip Jones, Masaru Koike, Carl Lum, Bal Raj Mehta, Noboru Oishi, Henry T. Oyama, Hideo Oshiro, Alan Pavel, Jordan S. Popper, Alexander Roth, Dudley S. Seto, Theodore K. L. Tseu, William Wilkinson, Lawrence Y. W. Wong, and Jerome L. Tucker.

Dr. O. D. Pinkerton presided over the installation of the new officers. Following the installation, Dr. Frissell presented the gavel to Dr. Winfred Lee. In a prepared speech, Dr. Lee presented his objectives and commitments to the Medical Society for the coming year and stated that he would strive to achieve the goals of the Society to the best of his ability.

Dr. Maurice Nicholson, commenting on the new RVS, stated that HMSA has adopted the 1970 RVS effective January 1, 1972, and that new claim forms will be ready for distribution to the doctors' offices soon. He urged the physicians to learn how to use the new RVS and to use it properly.

The following amendments to the Bylaws were voted on by the membership and were approved:

Amend Chapter I, Section 2, A, (2), (a) by the addition of the words "medical students at the University of Hawaii School of Medicine or" between the words "be" and "physician" in the first sentence.

Amend Chapter VI, Section 2, (c) by the addition of the words "medical students" between the words "for" and "interns" in the first sentence.

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

November 12, 1971, 5:00 P.M.
Mabel Smyth Conference Room

PRESENT:

Dr. Herbert Y. H. Chinn, presiding; Drs. William E. Iaconetti, John J. Lowrey, Thomas P. Frissell, George H. Mills, William W. L. Dang, Grover H. Batten, H. William Goebert, Jr., Peter Kim, Ed B. Helms, George Goto, Winfred Lee, Charles Judd, Jr., J. I. F. Reppun, J. Mark B. Sowers; plus Mrs. Helen Fujita, and Messrs. V. Thomas Rice, Tom Thorson, Jon Won, and Tom Leineweber.

CALL TO ORDER

The meeting was called to order by President Herbert Y. H. Chinn.

MINUTES

Minutes of the August 20, 1971, meeting were approved as circulated.

COMMUNICATIONS NOT REQUIRING ACTION

Announcement from the Hawaii Nurses Association of their 40th Annual Banquet, November 19, 1971, inviting physicians to attend.

COMMUNICATIONS REQUIRING ACTION

Letter written by HMA President inviting administrators and Negotiating Teams from Honolulu hospitals to a joint meeting on November 21, 1971, with representatives from the University of Hawaii. The Association supports a degree granting medical school and the principle of using local hospitals for teaching purposes, and is concerned that negotiations proceed in an orderly and expeditious manner.

REPORT FROM THE COMMISSIONER ON INTERNAL AFFAIRS

A. ANNUAL MEETING—1972

(1) Proposal to change banquet date: The Arrangements Committee recommends to the Council to hold the 1972 Annual Banquet on Friday, May 12, 1972, instead of Saturday, and to eliminate Sportsmen's Night for this year. Primary reason for this recommendation is that it would save the Association \$750 for one day's rent at the Ilikai. (The Ilikai does not charge rent on the day of a banquet.) In addition, it was felt that more neighbor island delegates and mainland guests would be in a better position to attend a Friday banquet rather than waiting until Saturday. This change should not pose any problems logistically for the exhibitors, although there would be less time to vacate the exhibit area.

ACTION:

Motion was made "to accept the Commissioner's proposal to change the date of the banquet, and to eliminate Sportsmen's Night for the 1972 meeting." Motion did not pass.

After some discussion it was agreed that, although the Council appreciates the Committee's recommendation to save \$750, Sportsmen's Night should remain an integral part of the Annual Meeting.

(2) Guidelines for displays and exhibits: The Council requested the Arrangements Committee to follow last year's guidelines in selecting displays and exhibits for the 1972 meeting. Guidelines for future meetings will be studied and presented for Council approval at a future date.

(3) Registration fees and dues waiver categories:

ACTION:

Motion was made, seconded, and passed "that we accept last year's policies regarding registration fees and dues waiver categories for the 1972 meeting."

UNFINISHED BUSINESS

A. CANCER PROGRAM IN HAWAII

Request has been received from the University of Hawaii to have representatives on the HMA Cancer Commission. Non-member appointees to HMA committees would necessitate changes in the Association's Bylaws. This matter was referred to the Bureau of Research and Planning to report back to the Council what part HMA should play in the overall cancer program for the State, and especially regarding the Cancer Registry.

B. LEGAL CONSENT OF MINORS

Dr. Goto, chairman of HMA's Legislative Committee, presented for discussion and Council approval a proposal concerning the legal capacity of minors for hospital, health clinic, medical, surgical, and dental care and services.

ACTION:

Motion was made and seconded "where any minor, 16 years of age or older, can consent to medical care and services." Motion did not pass.

NEW BUSINESS

A. OSTEOPATHS

Dr. Sowers gave an informational report relative to a meeting he attended on October 26, 1971, with the Osteopathic Association. According to Dr. Alan Becker, president of the Hawaii Osteopathic Association, question arose two years ago regarding the establishment of a common licensing board between the medical profession and osteopaths. The osteopaths do not wish to consider this and did not take a position. Dr. Becker has extended an invitation to members of HMA to attend their national convention in Honolulu on November 14, 1971.

B. VENEREAL DISEASE CONTROL PROGRAM

The Communicable Disease Committee presented for Council approval, recommendations to the State Department of Health for a comprehensive program to combat venereal disease. These recommendations from HMA are to be submitted jointly with the Health Department to the Legislature in December.

ACTION:

Motion was made, seconded, and passed "to accept the recommendations as presented in toto."

WOMAN'S AUXILIARY

Mrs. Fujita reported that the Woman's Auxiliary offered to undertake a project in the area of drug abuse and was wondering about assisting with an amphetamine survey but did not know how to proceed and asked for Council advice. It was pointed out that this work would be a duplication of effort since these results would be readily attainable from the Department of Health.

HMA EVALUATION BY AMA SURVEY TEAM

Balance of the meeting was devoted to reviewing the HMA Evaluation Report as submitted by Mr. David Weihaup, Team Coordinator of the AMA Survey Team. Mr. Weihaup is Assistant Director for the AMA Field Service Department. Other members of the Survey Team were Dr. James Sammons, President of the Texas Medical Association, Mr. W. Harold Parham, Executive Vice

continued page 54

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION CHONG, *Board of Directors:* NELLIE CHANG, WALTER HARANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, WILFRED OGOMORI and BETTY BELL.

Physician-Pharmacist-Patient

In today's consumer-oriented climate, the demand of our populace for a universal health care plan that will provide, (1) quality health care, (2) availability of complete health services, and (3) reasonable costs for these services for *all* Americans must be heeded. Those of us in the health care field must move collectively and positively in contributing our knowledge, skill, and material worth to the shaping of our future in this rapidly changing health care environment. The lack of communication and mutual respect between our interfacing professions has contributed measurably to the increased litigation for alleged negligence by the consumer or patient who has received less than optimal care from his health care team. The aggregated medical disciplines (medicine, pharmacy, nursing, etc.), hospital administration, and the legal profession must desist from their individual professional sacrosanct isolationism. *We* must work together via open communication channels to effect a comprehensive health care plan that will meet the demands of the American public and remain consistent with our basic medical ethic. Toward this communication goal, we shall speak of the isolationism between medicine and pharmacy, and how unified efforts by both professions can benefit the care of the patient and our own respective public images.

THE PHYSICIAN . . . Medicine abounds with men and women of vision who continually strive to utilize new methodology and electronic equipment to speed diagnosis and treatment. They pursue opportunities to share facilities, equipment, and expertise to provide quality medical care to Mr. Average Citizen at the least possible cost. Physicians are examining objectively possible benefits of physician's assistant and nurse-practitioner programs . . . medicine *should* examine the opportunities to utilize the presently available expertise of the pharmacist in his (physician's) outreach to meet the pressures of the public's demand upon his time.

In matters of life and death there is little margin for error . . . the physician must know his team . . . their strengths and weaknesses . . . he must extend himself through others according to their competence, knowledge, and skill to effect optimal patient care at minimal cost.

Medicine, as pharmacy and the other professions, have their share of lazy practitioners—those that don't keep up to date with the latest developments in their field. Those that would prefer to practice medicine at their medical school graduation level and who often times supplement their lack of diagnostic expertise and follow up by amelioration of symptoms via analgesic dispensing.

Medicine has been shocked by the advance of consumer controls already imposed on their disciplines; the pressures of the Medicare act for peer review, the reduction of their fees without their consent by government and third party payers. The "do more for less" edict—and "do it better even with fewer practitioners"—calls for a new kind of medical practice—a public interested practitioner willing to concentrate his professional attention on the development of improved health care concepts on a full-time basis. To this "physician" we intrust the future of the Health Care of the American People. He will rise above the petty fractionalization of the medical dis-

ciplines, accepting his responsibility for the regulation of our somewhat contentious professions and place equal emphasis on the powers of discipline in direct proportion to his responsibility.

The medical care professions, undisciplined and unregulated, will destroy themselves, will fail in their mission, and will not restore public confidence in the professions. *"United we stand, divided we fall."*

THE PHARMACIST . . . pharmacy, too, has many men and women with vision and a perceptive knowledge of the overwhelming demands on their profession to elicit and stimulate change among their own if they are to contribute their fair share to the new dimension of health care now demanded by the public sector of patients, present and future.

We, pharmacists, are guilty of the most widespread, "full press," isolationism of any of the medical disciplines. We have failed miserably to inform our medical colleagues and the patient public of our expertise in clinical pharmacology and the reservoir of talent we represent—untapped and often disintegrating from disuse.

Colleges of Pharmacy across our great nation are meeting the challenge of the new dimension in health care. Pharmacists graduating from the five and six year programs today are well versed in clinical pharmacology. Many educational programs find pharmacy and medical externs side by side making clinical rounds as a team, each contributing dialogue in his particular area of expertise on a particular case being examined. In these teaching hospitals, where the pharmacist and the physician train together, the patient enjoys the special benefit of their team effort in reducing drug interaction, consultation on the drug selection for the physician's diagnosis, admission drug history, and its subsequent effect on laboratory findings, etc. If the pharmacist has proven his worth in the dissemination of drug information and drug distribution in the teaching hospital, why not here . . . in Hawaii . . . in our hospitals and community pharmacies?

In essence, we have "lazy practitioners" too. Many of us fail to keep current with the ever-increasing advancements in clinical pharmacology . . . we are not willing to pay the price of sacrifice, turmoil, frustration, and incessant effort to tell our story by example! It's much easier to "let George do it" and to merely perform the basic drug distribution function of our profession without the benefit or concern for the treatment of the whole patient. Generally these are the *very practitioners* who will yell the loudest when they are ignored by the government, the third party payers, or by their local county medical associations.

The answer is not a simple one, for it demands mutual respect between all medical disciplines and a completely open line of communication unencumbered by self-interest.

It will take a lot of courage to utilize this new clinical pharmacology expertise in Hawaii's hospitals and community pharmacies. The goals of the community pharmacist, whether working as an independent or with a large chain, will have to be oriented toward better and concerned patient care.

But you say, I graduated from pharmacy school prior to the advent of patient oriented curriculums. So did I,

and so did most of Hawaii's pharmacists . . . for those young people just graduating from the six year doctor of pharmacy programs, with maximal clinical training, cannot meet the residency requirements of our Hawaii Law, and so they go elsewhere . . . a sad loss to the health care community in Hawaii. We do not educate our own pharmacists; we must depend on mainland universities to train our children and to provide the additional pharmacists necessary to meet the pharmaceutical needs of our people. We're not doing such a good job. The average ratio of pharmacists to population is 65 pharmacists/100,000 people. Hawaii has only 29/100,000; the poorest record in the 50 states. Does that mean that Hawaii does not acknowledge the value of pharmaceutical services for its people? I don't really think so. . . . Again, we haven't told our story. We must demonstrate our worth! Let's change the residency requirement! What about a pharmacy school at the University of Hawaii?

In the meantime, let's look at ourselves . . . most of us are well grounded in basic science and have a rather extensive knowledge concerning the physical, chemical and pharmacological properties of drugs and dosage forms. Our knowledge of drugs is excellent, rarely can the physician equal the pharmacist in this respect; but, we *are* lacking in knowledge about the patient, *the* most important consideration. Without an appreciation of the patient's problem and an understanding of the disease state or treatment, the pharmacist cannot relate his knowledge of drugs and dosage forms to the practical problems of therapeutics. An unnecessary waste.

It is up to us to plan ahead in order to accumulate as much information, patient exposure, and the continuing education opportunities necessary to arm ourselves with the tools for the practice of clinical pharmacy in any patient setting—whether it be the corner drug store, the hospital, or industry. Even with Hawaii's geographic isolation and the lack of a pharmacy school, there is a wealth of continuing education in tapes, institutes, and journals available to all pharmacists everywhere. Let's use them!

As we strive to update our clinical educations, will our corporate or independent employers permit us to practice clinical pharmacy and meet the pharmaceutical needs of the whole patient? I think so. After all, employers are interested in reasonable profits without the sting of malpractice actions. Personalized patient records and the pharmacist's concern for the patient's special problem will develop patient loyalties that cannot help but reflect increased prescription volume and better patient care.

Will physicians respond to our efforts to improve the flow of information regarding drugs and its application to their patients. The answer is yes again—provided we pharmacists arm ourselves with as much education and facts as possible before we offer him the service. Most physicians haven't the time to worry about proper storage of drugs, inventory controls, BNDD regulations, evaluation of the literature to select the most efficacious drug at the best price for their patients, etc., required to dispense medications themselves. Nurses are also becoming increasingly reluctant to practice pharmacy without a license. In brief, the physician's diagnostic and treatment expertise is too valuable, and in too short supply to dilute with a function that can be better placed elsewhere. The physician that willingly considers objectively the possible benefits of nurse-practitioner and physician assistant programs will certainly take a second look at how he might better use the expertise of the pharmacist. Perhaps we should start by activating a state association physician-pharmacist committee to explore avenues of common interest to benefit patient care.

In conclusion, we all realize that medical care in America is not perfect, and it probably never will be; but, our whole team of medical professionals do the best they can with the knowledge, techniques, and equipment available to them. It is exemplary that we keep striving to make medical care more available, affordable, and adaptable. We continue to place increased emphasis on continuing education and to involve more disciplines

in the treatment of the whole patient via completely open communication channels.

American medical care is the best and with the cooperation and participation of a dedicated medical community it will be better! A quotation from the late Martin Luther King seems to fit both the profession of medicine and pharmacy to which this article is directed.

"We ain't what we ought to be, and we ain't what we're going to be, but thank God, we ain't what we used to be."

PHARMACY—Is YOUR Chosen Profession

1. *Do you choose to have your future totally subservient to consumer and special interest group pressures?*
or
2. *Do you choose to have one authority representing you and your profession nationally and directing your future? SIMPLY—Do you wish to have a "VOICE"?*

PHARMACY HAS BEEN "ZONKED" AGAIN. A Health Services Industry Advisory Committee has been established to control the application of the phase II economic stabilization program guidelines for the health industry.

Barbara Dunn, Commissioner of the Connecticut Department of Consumer Protection, has been selected to chair this committee composed largely of physicians, health insurance specialists, hospital officials, a nurse and a dentist. The PMA is represented by President Stetler; American Hospital Supply by President Carl Davis. These two men do not represent pharmacists but drug suppliers. Pharmacists are not represented—yet we are surely going to be controlled by their directives. Already we've seen the first effect.

Very likely we shall be required to post prescription prices for either the 40 items with the largest sales or those prescriptions which accounted for at least 50% of the total prescription department volume during the last fiscal year. In addition to posting the prices described, we must also display a sign stating that price information on other prescription items will be available within 48 hours upon written requests.

The above decision has at this writing not been implemented. Wouldn't it have been better to have a pharmacist on the Board to explain simply that medications legally requiring the professional services of a pharmacist cannot be considered general items of commerce and are more properly applicable to regulations described as "service organizations," which are defined to include those persons providing professional services. Hopefully, we can still deter implementation of this decision, but the Price Commission did base its decision on a legal precedent that, despite a pharmacist's professionalism, he must comply with all regulations set down for retailers because his services are performed in a retail establishment.

Why has Pharmacy been ignored again? *Maybe the government just doesn't want to get involved with a profession that is represented by two national organizations with politically competitive views.* Therefore, Mr. Nixon chose not to favor APhA or the NARD by selecting one of their members to represent the pharmacist. Result—110,000 licensed, practicing pharmacists in this country have *no* voice.

110,000 pharmacists can be heard if you and I care enough to demand unification of these two politically divergent national pharmacy organizations. It is time that our younger colleagues get involved and informed at the national level . . . their future and their profession depend on it.

Why should we pay dues to 50 state organizations, numerous local groups, two national groups and often one or more sections of the national bodies? Costs of newsletters, maybe 60 or more, all carrying the same news item, plus staff, etc., represent a duplicity of pyramiding costs and fees that price the individual practitioner outside the circle of possible membership. Maybe this is why less than 50% of our number support our national organizations and even fewer support the state and local groups. Why not one dues structure to one large unified

continued page 52

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Hawaii Pharmacists' Bull. continued from 51

organization that could maximize efficiencies and provide Pharmacy the needed strength in Congress.

Will we again sit and argue about what should have been done after the public and government have determined how and for how much pharmaceutical services shall be provided? I hope not—but *You* have to act *Now*—or your future will be determined by someone else!

I charge you all—elect men and women, locally and nationally, to represent you who will actively promote *ONE* organization for pharmacy. Stand on your own feet. Don't be swayed by those somewhat older, influential, more conservative pharmacists with status quo ideas who have dominated our organizations for so long. One Voice has one Vote—make yours count.

The best investment you may ever make is your national association dues forwarded with your personal directive to immediately activate Interpretation #1 of Irving Rubin, editor of *Pharmacy Times*, partial solution to our problem . . . in a November, 1971 editorial, Mr. Rubin stated:

"For nearly three decades, I have heard talk of 'One Voice for Pharmacy.' This concept can be interpreted in 2 possible ways. First, that the various national pharmacy associations form one joint committee. Such a joint committee would analyze various problems, and have the *authority* to come up with solutions which would then be enunciated as 'One Voice for Pharmacy.'

"The second interpretation involves one national pharmacy organization.

"Interpretation No. 1 can be achieved almost immediately. It's a short-term goal, whereas Interpretation No. 2—relatively speaking—is a long-term goal."

This writer feels strongly that we must act today if we are to enjoy self determination. The joint committee so formed *must* have the power to act as *One* voice for all pharmacists—it must *not* be just another committee to study a problem.

Survival of the profession of Pharmacy is directly related to your dedication to act for "One Voice" for one large unified organization for all of America's 110,000 pharmacists. Today!

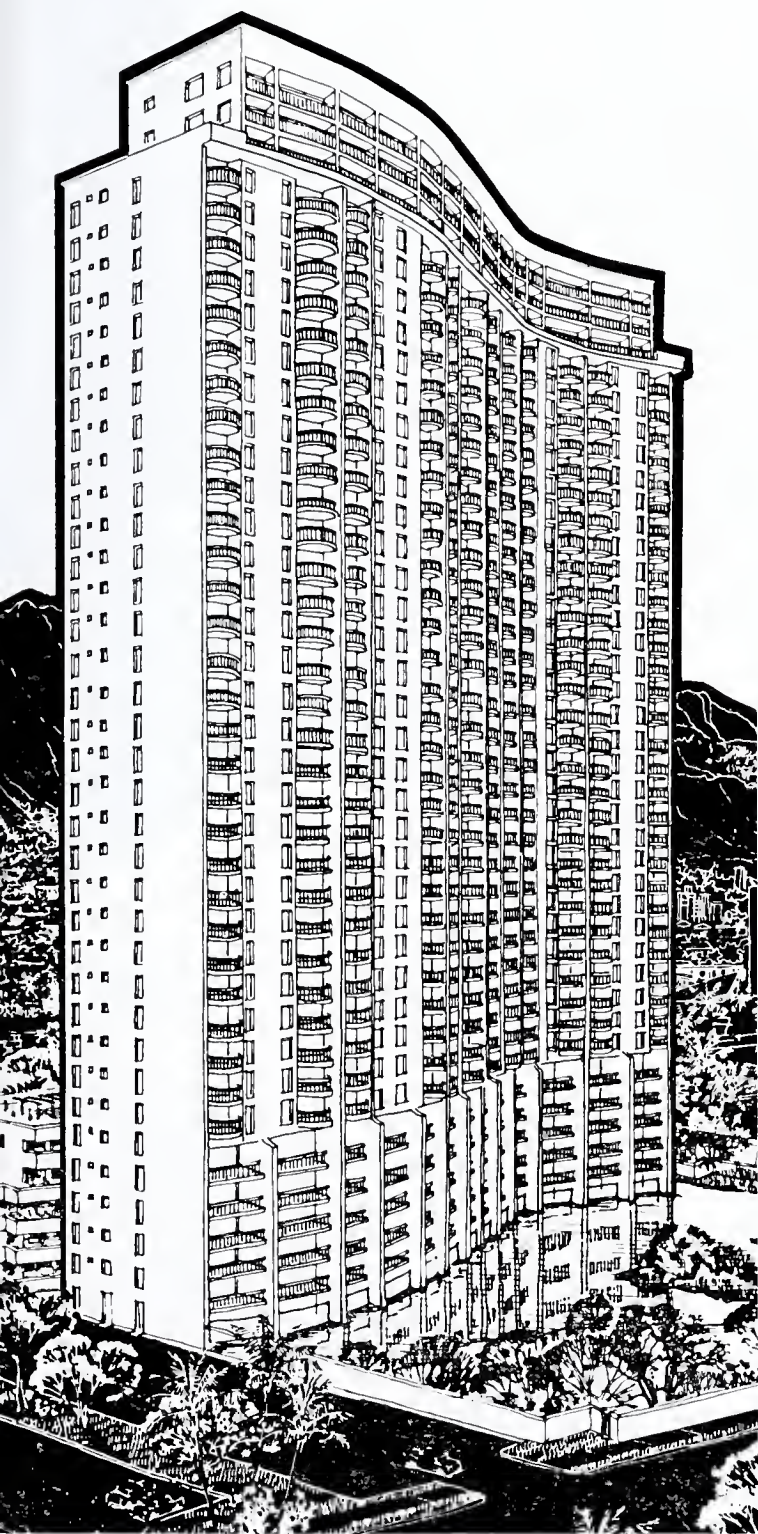
EXCERPTS OF INTEREST

A study by Researchers at Temple University's School of Pharmacy, Philadelphia, concluded that the presence or absence of third party sponsorship of prescription drugs does not appear to alter physicians' tendencies to specify generic or trade name drugs.

Community pharmacists can assist their medical colleagues and their patients by advising the patient to relate to his physician the O.T.C. medications he is talking prior to submitting to a laboratory work up. For example a patient who is self administering Ascorbic Acid to himself will reflect an increased level or false positive finding in Uric Acid, Glucose with Benedicts Soln or Clinitest, and Creatinine determinations. Glucose procedures (via urine enzymatic methods; dipstick) respond with decreased levels or false negative findings. In all procedures mentioned, Ascorbic Acid causes chemical interference with the test.

Prostaglandins, a generic term for polyunsaturated C-20 fatty acids presently found in many human organs but in highest concentrations in seminal fluid are finding usefulness as effective abortifacients and as antisterility agents in males. They are also finding usefulness in disease states of hypertension, asthma, and peptic ulcer. Prostaglandins are still experimental and further clinical investigation is required before they will be available commercially.

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Hawaii Medical Ass'n continued from 49

President, Florida Medical Association, and Mr. Richard Layton, Director, AMA Field Service Department.

The Evaluation Study was conducted in August 1971 at the invitation of the HMA to supply an in-depth report of the entire structure of the Association, its internal operation, its staff, and posture of the Association with component societies, allied medical groups, the community and membership. After the Council reviewed all areas of the Study and its recommendations the following actions were taken:

ACTION:

Motion was made, seconded, and passed "to form a committee made up of the five immediate past living presidents of the HMA to go over this Report and to make definite recommendations to the Council; and that the chairman of this committee shall be Dr. George Mills." (The five past presidents are Drs. John J. Lowrey, George H. Mills, B. A. Richardson, Theodore T. Tomita, and O. D. Pinkerton.)

ACTION:

Motion was made, seconded, and passed "that this committee be allowed \$500.00 to be drawn as needed."

NEXT COUNCIL MEETING

The next meeting of the Council was set for Friday, January 7, 1972.

ADJOURNMENT

Meeting was adjourned at 11:15 P.M.

COUNCIL MEETING

January 7, 1972, 5:00 P.M.

Mabel Smyth Conference Room

PRESENT:

Dr. Herbert Y. H. Chinn, presiding; Drs. William E. Iaconetti, John J. Lowrey, R. Varian Sloan, Thomas P. Frissell, William W. L. Dang, Grover H. Batten, H. William Goebert, Jr., Peter Kim, Ed B. Helms, George Goto, Cesar B. deJesus, Winfred Lee, Calvin Sia, Coolidge Wakai, Charles Judd, Jr., Denis J. Fu, Rowlin L. Lichter, J. I. F. Reppun, Elisabeth Anderson, Wilbur S. Lummis, and Ira Hirschy; plus Mrs. Helen Fujita, Messrs. V. Thomas Rice, Jon Won, and Tom Leineweber.

CALL TO ORDER

The meeting was called to order by President Herbert Y. H. Chinn.

MINUTES

Minutes of the November 12, 1971 meeting were reviewed. The Commissioner on Legislation pointed out that two motions passed by the Council on the Legal Consent of Minors were omitted. The actions are as follows:

(1) that "we support the bill which would allow minors 18 years of age or over and married, or have been married, be given full legal capacity in full medical surgical care as if these were adults."

(2) that "minors from the age of 14 years of age and older can consent to the medical treatment of substance abuse."

ACTION:

Motion was made, seconded, and passed to accept the minutes as amended.

COMMUNICATIONS REQUIRING ACTION

Letter was received from Dr. Alan B. Osher, Director, Regional Pediatric Pulmonary Program of the State of Hawaii, requesting endorsement of the continuation of the project. This program, at Kauikoolani Children's Hospital, has been funded largely through Regional

continued page 56

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Medical Program support, but the continuation of funds seems unlikely and negotiations are underway for application for funds through other means.

ACTION:

Motion was made, seconded, and passed to send a letter of endorsement.

REPORT FROM THE SECRETARY

The Report was reviewed, discussed, and approved as circulated.

REPORT FROM THE TREASURER

The Report from the Treasurer was approved subject to audit.

REPORT FROM THE COMMISSIONERS

A. COMMISSION ON PUBLIC HEALTH

Cancer Committee: The committee has been discussing the need for a blood cell separator. It is recommended that HMA write to the Blood Bank asking them to seriously consider obtaining either an AICO or IBM Blood Cell Separator.

ACTION:

Motion was made, seconded, and passed "that the Council encourage the Blood Bank to purchase the Blood Cell Separator for use and treatment so that they could use it for other things as well."

Chronic Illness and Aging Committee: This committee supported the concept that Diabetes, Heart, and Chronic Illness & Aging Committees could merge. It was pointed out that an ad hoc committee composed of all the commissioners is to be formed, with one commissioner appointed chairman, to review the various committee and commission struc-

tures. This ad hoc committee shall be asked to study the possibility of consolidation or elimination of committees, or amalgamation with similar County Society committees, and to submit its recommendations to the House of Delegates in May 1972.

Communicable Disease Committee: The committee voted to recommend that HMA defer action at the present time in making specific recommendations on the smallpox immunization program in the State. It is felt that more information should be disseminated to the practicing physician first to get reactions on this subject prior to a final statement whether this procedure should continue as mandatory or elective.

School Health: The committee's endorsement of a resolution to seek legislative action for administration of emergency medications in schools was discussed. It was decided to defer action until more specific information and a recommendation are received.

B. COMMISSION ON MEDICAL SERVICES

Fee Survey Committee: Dr. Judd reported that the Fee Survey Committee, together with HMSA, sponsored a series of seminars on the use of RVS. These seminars were held in December throughout Oahu and the neighbor islands. Currently, plans are underway to issue an errata sheet on the 1970 RVS.

Committee on Underprivileged Medical Care: Executive Director, Mr. Thorson, has had several meetings with Mr. Yuen of HMSA and Mr. Millar of DSS relative to DSS fee schedules. Mr. Thorson, however, could not be present to make a report on those proceedings.

ACTION:

Motion was made, seconded, and passed "that the Committee on Underprivileged Medical Care meet with DSS and report back to the Council

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with a recommendation on what action HMA should take regarding the usual and customary fees."

Workmen's Compensation: The Workmen's Compensation Committee was urged to work with the Legislative Committee in proposing a bill at this legislative session. Legal Counsel stated that legislative changes should be pursued at this session and that the bill should include the subject of reviewing the schedule at fixed periods of time, not less than two-year intervals, and to amend to eliminate rigidity of schedule so that the usual and customary fees could be used.

C. COMMISSION ON INTERNAL AFFAIRS

Scientific Committee: All guest speakers are confirmed for the Scientific Sessions for the Annual Meeting in May. Over \$1,000 in grant-in-aid has been received from various pharmaceutical companies in support of speakers. Booths for exhibit space are almost all sold.

Arrangements Committee: In view of the last Council action which vetoed the Commissioner's recommendation to change the date of the Banquet and to eliminate Sportsmen's Night in order to save one day's rental, Dr. Wakai presented a counter-proposal. The new recommendation is to have the Banquet on Friday night and to have Sportsmen's Night at a different locale on Saturday, thus saving the cost of rent at the Ilikai and still maintaining the traditional Sportsmen's Night.

ACTION:

Motion was made, seconded, and passed to accept the recommendation of the Commissioner on Internal Affairs.

The following sports activities are being planned: Golf Tournament at Francis H. Brown Golf and Country Club, May 12; Skin Diving at Kalaupapa, Molokai, April 22-23; and Bow and Arrow Hunting on Big Island, May 5-7. Plans are also underway for a Fishing Tournament on May 7 and Tennis Tournament on April 30.

D. COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH

Publications Committee: The committee recommends that the HAWAII MEDICAL JOURNAL increase its subscription rates to \$8.00 per year subject to legal approval. The present rate of \$6.00 has not been increased in the thirty years the JOURNAL has been in circulation.

ACTION:

Motion was made, seconded, and passed to accept the recommendation.

Hospital Committee: Dr. Liu was commended for his role as chairman of this committee in conducting meaningful discussion meetings with local hospital chiefs-of-staff and with representatives from the University regarding the proposal for a 4-year medical school.

Medical Education: This committee is also involved with University negotiations and is coordinating the Ambulatory Care phase of the HMA-Payne Study.

E. COMMISSION ON LEGISLATION

Legislative Committee: (1) Legislative Counsel—The committee recommends that HMA retain the services of Mr. Ben Kaito. He will assist in the development of HMA's legislative program.

ACTION:

Motion was made, seconded, and passed that HMA retain Mr. Kaito as its Legislative Counsel.

(2) Legal Capacity of Minors—Request was made by the Commissioner to reconsider the last Council

action relative to providing contraceptives to minors 16 years of age or over in the Minors Consent Bill. (Copy on file in HMA office.) The chair ruled that reconsideration of a previous action of the Council would require a two-thirds vote. However, the chair's decision was appealed, and carried, since the bill now under consideration is not the same as the previously submitted bill.

ACTION:

The following motions were made, seconded, and passed to amend the Bill:

"that on page 2, under A, the words 'contraceptive services' be deleted and substituted with 'family planning services.'"

"that 'Surgical and Dental Care' be deleted from the top of the first page, and that item (b) at the top of page 3 be deleted which relates to minors who are married or who are 18 years of age or older receiving same services as minors who have achieved the age of majority."

ACTION:

Motion was made, seconded, and passed to accept the Bill as amended.

F. COMMISSION ON INTERPROFESSIONAL AND PUBLIC RELATIONS

Television-Radio Committee: Announcement was made that "Medically Speaking," HMA's weekly television program is to be discontinued at the end of January. Although this action seems to be a temporary course of action taken by the station, the future of the medical program appears uncertain unless problems at KHET-TV are resolved.

Association of Professions: Considerable interest has been expressed by the other professional groups in establishing an Association of Professions in Hawaii. Meetings are to be scheduled at different sites. The committee voted to have Dr. Schnack and Dr. deJesus represent the Hawaii Medical Association at these meetings.

ACTION:

Motion was made, seconded, and passed to approve the appointment of Dr. Schnack and Dr. deJesus as representatives of the HMA Association of Professions Committee.

Careers Committee: The Health Careers Council of Hawaii has been reactivated. Present plans are to schedule a Health Careers Day in November 1972 at the Honolulu International Center.

G. BUREAU OF RESEARCH AND PLANNING

Cancer Program: In line with the assignment from the Council, the Bureau of Research and Planning has been studying the problem of the Cancer Committee and the Cancer Commission. They are in the midst of meeting and discussing the issue with Drs. Will, Lau, Stemmerman, and Batten. Until everyone has had a chance to express their viewpoints, the Bureau is not in a position to make a recommendation. It is hoped that a report will be ready for the Council before the House of Delegates meeting in May.

UNFINISHED BUSINESS

A. CANCER PROGRAM

The President reported that HMA received a protocol from the Research Corporation of Hawaii relative to the Demographic Cancer Research and Training Program in Hawaii. A meeting has been scheduled with the Cancer Committee and representatives from the National Cancer Institute regarding cancer research and they will be reviewing this protocol. Dr. Chinn felt that the proposal also involved clinical components of cancer and he expressed concern that HMA, which is representative of organized medicine and clinical physicians,

is not involved in the planning or preparation of this program.

A letter from the Research Corporation of Hawaii written by Dr. Richard K. C. Lee, Chairman of the Legislative Task Force, Demographic Cancer Research and Training Proposal, states that it was proposing two measures relative to the reporting of cancer and an Advisory Committee to the Tumor Registry. These two proposed amendments to the Hawaii Statutes were read in toto to the Council. They are as follows:

(b) Reporting of cancer required. It shall be the duty of every physician to notify the Health Department of the name, address and such other items as may be specified by the Director of Health of any person by whom such physician is consulted professionally and who is found to have cancer of any type or who is suspected of having cancer of any type. Report shall be made within five (5) days after obtaining reasonable evidence for believing that the person is so afflicted. The forms used for reporting shall be prepared and supplied by the State Health Department.

(c) Cancer Advisory Committee. There shall be an Advisory Committee for the Tumor Registry made up of representatives from the Hawaii Medical Association, the Hawaii Cancer Society, the University of Hawaii, and the Health Department to advise the Director of Health and his staff in the management, collection and utilization of all such data. The composition of this committee, its functions, and terms of office of its members shall be the responsibility of the Director of Health.

The Council discussed these two legislative proposals and it was felt that some definite action should be taken with regard to these two amendments.

ACTION:

It was moved, seconded, and passed that the Council go on record as opposing the two proposed amendments to the Hawaii Revised Statutes relating to (b) Reporting of cancer required, and (c) Cancer Advisory Committee.

B. STATUS OF SCHOOL OF PUBLIC HEALTH

Dr. Lowrey reported that the School of Public Health is applying for a grant for the continuation of the study of the school health project to study health systems. Either the Health and Community Services Council of Hawaii or the Regional Medical Program is to be the sponsoring agent.

NEW BUSINESS

A. Physician's Assistant

The President reported that there seems to be some confusion in regard to the AMA position on physician's assistant and action of licensure of these types of personnel. Mr. Won was asked to read from the *AMA Quick Reference Guide to Policies, Positions and Statements*. In essence, the AMA recommends a holding action licensure of any additional allied health occupations until long-term solutions are developed. AMA also strongly endorses the concept of innovation and experimentation in developing new categories of health manpower, and has approved guidelines which specify desirable steps to be taken by any group attempting to develop a new health occupation. Mr. Won then read the definition of a physician's assistant by the AMA, which is as follows:

"A physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

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It was reported that at the last AMA House of Delegates meeting, the delegates approved that AMA take a leadership position in training programs for physician's assistants through medical schools and that the AMA also become deeply involved in setting guidelines for the training of the physician's assistant.

B. AMA Evaluation of HMA

Dr. Lec reported that the Honolulu County Medical Society has also appointed a committee to study the AMA Evaluation of HMA. Their committee is composed of the four officers and immediate past president. Dr. Dang is chairman. At its initial meeting, it became evident that no one organization is able to make a decision since four organizations are involved: the Hawaii Medical Association, Honolulu County Medical Society, Bureau of Medical Economics, and The Foundation. Any changes would require changes in the Bylaws of each organization. Of prime importance, it was felt, is to define the specific roles of the State Association and the county societies. Since most organizations look upon a state organization to be the spokesman, it was thought best for the State to set policies so that *all* county societies could follow the same rules instead of each acting unilaterally.

Regarding the site location, the committee recommended that the HMA Council ask its Legal Counsel "how," not "if," HMA can legally move out of the present site. Mr. Rice gave the following alternatives: (1) Get the nurses to agree with HMA, then (2) Get Queen's Medical Center to assume HMA's obligations, and (3) Cut down on maintenance costs to a point where moving could be possible with reasonable financial safety.

Dr. Lee urged all effort be made in making recommendations as soon as possible regarding the AMA Evaluation so that action can be initiated in changing

the Bylaws. Unless recommendations are submitted to the House of Delegates in May, action cannot be taken for another year.

C. Resolutions to the House of Delegates

Members of the Council were reminded that any resolutions to be submitted to the House of Delegates, May 1972, should be prepared as soon as possible.

D. President Nixon's Phase II Price Control

The proposed economic guidelines governing prices on non-institutional providers of health care were discussed. A letter was received from Dr. Ernest B. Howard, Executive Vice President, American Medical Association, expressing concern in three areas which AMA believes the Price Commission inadvertently proposed that would lead to unfortunate effects. The three areas of concern are (1) the proposed guidelines will lead to unintended discrimination against non-institutional providers; (2) the posting requirements will have no effect on inflationary causes; and (3) the proposed guidelines would result in the unfair treatment of certain non-institutional providers who would not be authorized to increase their fees to meet increased costs as a result of past inflationary pressures.

It was felt that the Federal Price Commission should not be discriminatory in limiting health professionals to an unfair percentage annual increase compared with wage-price rulings for other segments of the population. The Price Commission's ruling which limits annual price increases for non-institutional providers of health care to 2.5 per cent of allowable costs does not cover authorized increases in a physician's overhead expenses. In addition, most physicians discuss their fees with their patients and this should obviate the necessity of maintaining a schedule of base prices for their services.

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ACTION:

Motion was made, seconded, and passed to have the HMA President write a letter to the Federal Price Commission, incorporating the three points in Dr. Howard's letter, with copies of the letter to the President of the United States, all four of Hawaii's Congressional Delegation, the American Medical Association, and to members of the Hawaii Medical Association.

E. Guidelines for Contributions and Endorsements

The chair requested guidelines for the Association to follow regarding requests for financial contributions and for endorsements.

ACTION:

It was moved, seconded, and passed "to go on record to consider only those organizations of a medical nature, and to leave personal endorsements to the discretion of the doctor."

F. President's Assistant

Discussion was had regarding the continuation of the position of Assistant to the President.

ACTION:

Motion was made, seconded, and passed that this decision be left to the discretion of the President.

G. Letter from Dr. Verne L. Adams

As past-president of the Hawaii County Medical Society, Dr. Adams recommends that the Executive Director be authorized to summarize important items in committee reports and correspondence, and to combine them into one newsletter to the officers of neighbor islands. This suggestion was made by Dr. Adams in an effort to curb the expenses involved, and because of the difficulty in wading through many reports. Mr. Won pointed out that the administration is aware of the problem and a solution is being studied.

ACTION:

Motion was made, seconded, and passed to refer the matter to Mr. Thorson and Mr. Won for further study, with the results of their decision to be brought back to the next Council meeting.

H. Next Council Meeting

It was decided to schedule two more Council meetings before the Annual Meeting in May: Friday, March 17, 1972, 5:00 P.M., Regular Council Meeting; Friday, April 14, 1972, 5:00 P.M., Budget Meeting.

ADJOURNMENT

The meeting was adjourned at 10:30 P.M.

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appalling. An ambulance should virtually be an emergency room on wheels, an extension of the physician.

Physicians in Hawaii and all over the United States are slow about accepting the Physician's Assistant program, and with very good reason. However, Dr. Reppun suggests the idea of tapping the one source all of us tend to take advantage of, and that is the trained nurse. One could not conceive of a more excellent solution. As was pointed out, the nurse already does many procedures a physician does, and very well. The dedication, knowledge and experience most of these women have is invaluable. We all have seen them perform in every capacity in the CCU, ICU, SICU, ER and OR, and their performance is excellent. Not to mention the sometimes special insight a woman seems to have to be able to see into difficult situations in a different perspective than a man. Almost all of you employ them in your offices, and with more training and trust, they can and will do the job, much more economically and efficiently.

Doctor, the problems are great. However, they can be solved. It will take pressure by you, the physicians of Hawaii, the API, the ambulance attendants and the public to force the slow-moving legislature of Hawaii to provide the necessary funds to implement the programs we all need. And most important, it will take you, doctor, to give the paramedical personnel and Physician's Assistants the trust, the guidance and the help we need in order to help you. Gentlemen, you help lay the foundation, and we will help you to build it up.

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Howard Liljestrand president, Michael Hase president elect, Doris Jasinski secretary, and Fred Reppun, treasurer. New board members are Norberto Baysa, Clifford Druceker, and Varian Sloan. The American College of Surgeons elected Fred Warshauer to its board of governors at a recent Clinical Congress in Atlantic City, N.J. Kuakini Hospital re-elected Roy Tanoue to the Board of Directors and Children's Hospital elected Harold Sexton a trustee. The Chamber of Commerce nominated Masato Hasegawa as one of the candidates for its board of directors. The Hawaii Planned Parenthood elected Ronald Pion president and George Goto first vice-president.

On the political front, Richard Ando was reelected president of the State Board of Education and Robert Chung was confirmed by the City Council for another term as chairman of the Honolulu Police Commission. Timothy Woo of Hilo was named to the Board of Medical Examiners.

On the Tong front, Bernard Fong was elected to the Board of Trustees of the United Chinese Society.

The Blood Bank of Hawaii reelected F. J. Pinkerton president, Morton E. Berk vice president and elected to the board of trustees, Noboru Oishi, Irvin Tilden, Herbert Chinu, and Winfred Lee. The first American chapter of the Knights of Rizal was organized with Mario Bantista, Cesar deJesus, and Richard You as trustees.

Cal Sia was recently appointed to the National Advisory Child Health and Human Development Council of the National Institutes of Health, HEW.

DIALOGUE FROM THE AETNA MEDICARE REVIEW COMMITTEE (AT MON CHER TON TON)

Bill Dang reviewed the case of a recurrent inguinal hernia which had been repaired with a fascia lata graft. Chairman Gabe Ma was rather belligerent: "You and I would have taken ¼ of the damn time. You put me up as chairman again, so I'm going to be very malignant this year. . . ."

Henry Oyama reviewed the case of an elderly man with diabetic gangrenous toe who was being seen by the attending physician on home calls every day for several weeks; every day, that is, except on Sundays. Bill Dang questioned, "And never on Sunday?" Gabe: "This is a case of unusual judgment. We should allow debridement only twice a week." Bernie Fong wondered, "How much of a toe can someone debride and still have a toe left?"

Commenting on the transition in his own maturing practice, Bernie Fong states that when he first started practice, most of his patients asked questions about VD. Later, they kept asking about diets. . . . Now all they ask about is laxatives. . . .

Chairman Gabe Ma reviewed a plastic surgery case originally assigned to Vic HayRoe. Vic, however, had just had his gall bladder removed and was probably hooked up to IV's and on NPO. The Committee voted to send him a Mon Cher Ton Ton menu, a bouquet of Chinatown dry oysters and a sympathy card reading, "Wish you were here." As he finished his Green Tea Sherbet (a Mon Cher Ton Ton special), Bill Dang asked hopefully, "Now, where shall this Medicare Gourmet Club meet next?"

Medical Anecdotes

A frantic local gal comes into the ER, pounds her chest and gasps, "I have vagina pectoris. . . . Do something." "You must mean angina pectoris." "No, no, I have vagina pectoris." The bright ER intern thought a moment and prescribed, "Give her a peniscillin shot." (Contributed by Lovey Nabalta, CCU nurse who heard it from Ed Ichiriu.)

The Pope during his visit to the US was concerned about the little man's feeling about the Pill. He visited the Italian sector of New York City and came upon a vendor who immediately prostrated himself before the Pope, bowing and kissing the proffered hand. . . . "How do you feel about the Pill?" asked the Pope. . . . Came the answer in no uncertain terms, "Please, your excellency, if you no playa da game, you no make-a da rules. . . ." (Contributed by Diane Gabriel, Ewa HI nurse.)

A physician listening with his stethoscope to a teenager's chest mumbled, "Big breaths. . . ." The girl proudly puffed up her chest and declared, "Yeah, and I'm only 16 yet. . . ." (From Quint Uy.)

"You hear about that dreadful Egyptian Flu going around?" "What's it like?" "Well, there is nausea, progressive bloating, and the patient turns into a 'mummy' at the end of 9 months." (Chuck Frei from Toledo.)

Sportsmen

The annual John Takamura Invitational Golf Tournament was held at Mid Pac CC on December 5 with 32 participants. Clarence Sakai finally put his game together and shot a 83-17-66 to win over traditional grand slam winner Bill Dang who had a creditable net 69. Remarked Clarence in a post tournament dig: "I was happy to finally dethrone Bill Dang."

The annual Makaha Invitational (cosponsored by Paul Tamura and the BioScience Labs) was held on the November 20-21 weekend. Ed Izawa who had made a hole-in-one on the 9th hole last year shot nets 71 and 67 to win first place while Y. Fukushima had nets 70 and 78 to place 2nd. Last year's tournament winner Hide Oshiro slumped to a miserable 5th, but still won a Seiko watch. Don Maruyama who arranged for the tournament prizes is promoting Seiko watches this year rather than Sanyo products. . . .

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Personal Glimpses

After a board of governors meeting, we encountered **Bill Moore** about to pedal away from the Mabel Smyth Bldg. on his 10-speed foreign bike and learned that he has saved at least a third on his gas bill. . . . In this day of inadequate parking space and environmental pollution, he has the right attitude. . . .

Author-traveller-retired physician **Kazuo Miyamoto** returned recently from a 4-month tramp steamer tour of the Mediterranean countries with the Robert Markses. Kazuo's most recent work, entitled "Buddhist India, Ancient and Modern, A Travelogue," now at the publishers, is based on a trip to India in 1969. His present project is the romantic life story of a 17th century Japanese pirate, Yamada Nagamasa, who lived in Ayuthea, former capital of Siam, and who married the King's daughter and became a governor of a province. . . .

Physicians in Print

Human Pathology, Vol. 2, No. 2, June 1971: "Colchicine Intoxication: A Reappraisal of Its Pathology Based on a Study of Three Fatal Cases," **Grant N. Stemmerman, Takuji Hayashi.**

Sportsmen

From Bruce Carter's column, we gleaned that hard-fishing **Harold Sexton** on his Alokai made a "garrison finish" to nose out Dave Nottage for the Kaneohe Yacht Club's "Fisherman of the Year" honor, which is based on accumulated points over the 12-month period.

Yutaka Yoshida, whom an admiring patient we met adoringly calls "The Samurai Surgeon," feels that all tennis-playing physicians should join the AMTA. Life membership is \$10.00 and the money can be sent to: "Bill Drake, Executive Secretary AMTA, Box 183, Alton, Illinois 62002." We learned that **Hunky Chun, Leabert Fernandez** and **Yosh** are already members and that AMTA plans a tournament in Hawaii this year. . . .

Locker Room Quips

There is now a male counterpart of the feminine hygiene sprays called "Umpire." . . . It deals with foul balls. . . .

Rodney was to meet Louise at a certain corner on a blind date. As Rodney waited anxiously at the corner having arrived early, an attractive gal sashayed toward him at the appointed hour. "Are you Louise?" he inquired. "Are you Rodney?" she countered with an approving look. . . . "Yeah, I'm Rodney," he answered. As she turned and walked away rather hurriedly, he heard her say, "No, I'm not Louise." (Contributed by **Frank Fukunaga.**)

Medical Tidbits

Judson McNamara, director of surgical education at Queen's, circulated this item in his General Surgical Service Newsletter: "The Department of Surgery including its educational component has relocated its offices to the first floor of Harkness. Rumors that the move was undertaken to place the chief resident in closer proximity to the swimming pool are unfounded." The clincher was at the end of the newsletter: "Use of the swimming pool: hospital liability problems are delaying this implementation. This is where things currently stand. . . ."

A 57-year-old man with bronchiolar carcinoma of the lungs had lobectomy for an asymptomatic 1 cm lesion in the right middle lobe. Surgeon **William Morioka** added, "He runs 1 mile a day in the morning and has smoked a pack a day since age 14." Radiotherapist **Carl Boyer** remarked, "Now, I've always said that one shouldn't run in the morning. . . . I've always said that. . . ."

A 33-year-old Japanese woman with a firm, 6-7-mm, pea-sized, non-tender nodule in her right breast was found to have metastasis to the axilla. Pathologist **Grant Stem-**

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merman was agush: "This is one of the smallest primaries I've ever seen with axillary metastasis. A small carcinoma is not necessarily an early one. . . ." For borderline breast nodules, Stemmy advocates excisional biopsy and waiting for permanent sections and a definitive report. "There is no evidence whatever that excisional biopsy adversely affects survival. . . . I strongly urge that we reorient ourselves with regard to breast Ca, esp. in borderline cases. . . . They are impossible with frozen sections. . . ." Surgeon **Bob Oishi** bemoaned the difficulties with biopsies: "I've lost more blood with breast biopsies and small lesions are difficult to locate in the OR because of the positioning of the arm." The discussion developed into the difficulty of demarcating the apex in a radical-breast specimen and Stemmy recommended that a suture be placed at the apex. Color-conscious **Quint Uy**, nattily dressed in checkered sport coat, maroon shirt and a yellow and maroon checkered tie, asked, "What color suture do you want?"

We met **Gary Glober**, director of the Japan-Hawaii Cancer Study, who recommended: "Buy stock in Kellogg's. . . . We are using a lot of 'All Bran' in our meat-free diets for stool occult blood. . . ."

An 80-year-old woman with Ca of the esophagus was described as a well-developed, well-nourished Hawaiian-Chinese female [i.e., woman—Ed.] in "good temper" by intern **Masaaki Iwanaga**. Always interested in the epidemiologic aspect of cancer, Grant Stemmerman asked, "Does she smoke?" **Charley Judd**, the attending replied, "No she does not. . . . She's a good citizen." **Charles Tashima** was curious, "How about Chinese food?" Intern **Conradin Schrafl** contributed the information that Chinese men have more Ca of the esophagus than women

because they got to eat the hot food first. . . .

The Queen's CPC protocol read as follows: "Good morning! Thank you for attending this month's CP Conference. We hope this will be an enlightening conference and that the coffee is to your satisfaction." Unfortunately, the two coffee urns were empty by the time we got there, but we appreciated the friendly invitation anyway. . . . The case was that of a 64-year-old Hawaiian woman with a gamut of diseases including hypertension, diabetes mellitus, CHF, glaucoma, hysterectomy, bowel obstruction, etc., who on this admission complained of cough, shortness of breath, swelling of legs, progressive weakness, sweats, fever, and chills. At post, the pathologist found military Tbc, even though the chest x-rays were negative. **Richard Frankel**, resplendent in flaring hairdo and a 6-inch wavy beard, made the following points:

- The diagnosis of military Tbc is made more readily at a CPC.
 - The *New England Journal* reviewed 100 cases of F.U.O.'s; there were 11 cases of tuberculosis including 3 cases of miliary Tbc without any signs of active pulmonary disease and negative PPD's.
 - Hawaii has the highest rate in the U.S.
 - The predisposing factors in disseminated Tbc include hematologic diseases and corticosteroid therapy.
 - Tbc is no contraindication to steroids if Tbc Rx is adequate. . . .
 - In the diagnosis of miliary Tbc, liver biopsy, bone marrow, and history of exposure are helpful. . . .
- Medical director **Jim Orbison** was philosophical: "Everything is easily explainable with the progression of a disease. We have a tendency to look for the unusual and overlook the obvious."

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Hors de Combat

Medical examiner and yacht enthusiast **Al Majoska** was on hand to aid fellow yachtsman **Ez Parker** when he had his first heart attack a year ago, but when Ez had his second attack, during a funeral at sea, Al was unable to revive his friend. . . .

William Goto, part-time delivery man for the *Advertiser*, slipped and broke his leg very early one morning on his route. . . . Helpless, he sat in the Manoa rain and yelled for help. **Ed Boone**, a light sleeper like most physicians, heard the cries for help at 3:30 A.M. and sped to the rescue clad only in his pajamas. Ed gave Goto a shot, put on splints, and then called an ambulance. . . .

The H-3 opponents were making a last ditch stand. . . . **Arthur Molyneux** had collected 600 signatures, the most by any one person. The Moanalua Gardens Foundation was proposing a 3,000-acre historical park through the historic valley instead of the freeway. . . .

When the American Osteopathic Association met in Honolulu, AOA president **Marion Coy** said the organization had "reaffirmed its intention to remain separate and distinct and not merge with the American Medical Association." Coy reported that "merger offers have been made in one form or another year after year," but contends that "the AMA wants to merge because it feels it must rule everything in medicine—rule by absorbing others or destroying others. . . . The AOA believes that having two branches of the healing arts is a healthy situation. . . . We stand between the public and medical monopoly. . . . Monopoly in anything, including medicine, is not a good thing." We learned also that the difference between medicine and osteopathy is that "medical doctors

mostly treat symptoms until the cause goes away. Osteopathic doctors treat the cause and the symptoms go away." (So that's how it is done, eh?)

From Eddy Sherman's column, we gleaned the following: "**Stanley Batkin** worked his way thru medical school pounding a piano in N.Y. nite clubs." In yet another "Eddietorial" Ed reported: "The Nat'l Endowment for Humanities kicked in \$10,895 to the UH for a study of the Russian Revolution in 1917. A brilliant neurosurgeon and medical researcher has a small lab at the University of Hawaii. His experiments have produced some amazing results. He is working practically solo because he has hardly the funds necessary for more technicians and animals. There are papers available for examination about his work. Against great odds, he has made significant strides. Who can say if his theory will produce an important breakthrough? But—wouldn't it be more beneficial for a man like this at the University of Hawaii to have a chunk of money like the \$10,895, than to give it for study of the Russian Revolution of 1917????????? . . ."

In October on Kauai **Robert Hamblin** and **Peter Kim** had their car keys stolen from their cars at Wilcox Hospital. . . . Nothing else was missing. . . . Less lucky was **James Fleming** of Maui, who had his office burgled of drugs in November.

It seems that the 25-bed Molokai General Hospital is beset with economic woes partly stemming from the disension caused by the barring of a **Richard Zandee van Rilland**. Zandee, an orthopedic surgeon, a Dutch resistance fighter in World War II, spent more than two years in German prison camps. After losing his hospital privileges, Zandee played music—organ, piano and tenor

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sax—in Molokai bars and nightclubs to support himself. In August, the trustees overruled the medical staff's recommendation and reinstated Zandee (after a purported 1,000 of the total 5,000 residents of Molokai signed petitions urging his reinstatement). However, Zandee has not worked at the hospital because of the hostility against him, and he has a 3 million dollar lawsuit pending anyway. The medical staff is again recommending not granting him privileges again, because he is not a full-time resident of Molokai, he leaves the island without arranging for another doctor to care for his patients, and he fails to attend staff meetings regularly. . . . Tsk, tsk, tsk. . . .

Poor **Dick Ando** . . . he has a thankless job. . . . As chairman of the Board of Education, he was first collectively censured by the Hawaiian Association of Language Teachers in October. He retorted, "To say that I am arrogant and unresponsive to that organization's requests to meet with me is a personal attack that I don't fully deserve. . . . They should go through professional channels rather than try to deal directly with me or the board."

Then in December, **Dewey Allen** of the Model Cities Program criticized Dick for "his adamant position in refusing to let citizens speak at the board sessions." Dick contends that allowing citizens to raise questions on matters not on the board's agenda "could create havoc in getting things done."

Physicians Speak Up

In December, **Ira Hirschy**, our chief of the State's communicable disease division reported that "Hawaii is in the midst of a venereal disease crisis with no end in sight. . . . The reservoir of infection is massive and only by concerted action can we hope to make Hawaii a safe place in which to [no, not what you thought!] live and raise our families." Ira reported that for the first 10 months of 1971, cases of syphilis rose to 42 as compared to 30 cases for all of 1970, while gonorrhea cases rose to 1,646 for the same period as compared to 1,494 for 1970. Ira says, "Unlike an iceberg whose size can be calculated, the scope of venereal infections is difficult to assess."

We spoke to **Milt Trager**, who, alarmed by the increasing VD cases in his Waikiki practice, had proposed a project for providing the entire 900-strong hippie population on Maui with Vibramycin 100mg bid for 5 days, and providing an identification tag for those who had been treated. Pragmatist **Tom Thorson**, our HMA executive secretary, was quite explicit in his views: "It [the tag] sounds like a license to screw."

Rowlin Lichter, bless his observant soul, was incensed by the marked inequities in the quality of construction of the freeway sections done by different construction firms. He wrote: "My question is: How are these inequities adjusted? Obviously, the excellent work done by some of the contractors is of greater value to the State than the shoddy workmanship in other areas. . . . Some gross inequities are apparently being perpetuated by our present system. One must assume there is pork-barrelling here, but I wonder if it isn't going to an extreme when they start turning out construction like they have recently. It's a good thing we don't have California-type earthquakes, or the whole damn thing would fall down."

Robert Fisher, head of the Alcohol and Drug Abuse Section of the Health Dept., called Project Steppingstone's survey of transient youth in Kona an "unqualified success." A recent article in a *LA Times* supplement had claimed Hawaii had 3,000 longhairs, the majority of whom have settled along the Kona Coast, but the survey counted only about 500 members of the hip "target group" in Kona. Bob feels that this indicates a manageable situation which should reduce the hysteria of the community-at-large. The survey showed that 33% wish to remain, that 7.6% have had hepatitis, that 40% are working, and about 75% wish to improve their community relations. . . . Bob feels that the next step is a "rap center."

"The Name of the Game is 'Overtime'" (per **Tomi Knaeffer**) . . . **Aldon Roat**, head of the Division of Mental Health, reports on an overtime game being played

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by some Civil Service workers at the State Hospital—and other areas. It goes something like this: "I'll stay at home on sick leave today so you can pile up overtime. Next time you stay at home 'sick' so I can collect likewise."

We also learned from Tomi Knaefler's interview with **Sherrel Hammar**, director of ambulatory services and chief of adolescent medicine at Children's, that he has two ongoing adolescent programs, viz. an adolescent medicine program for youngsters in that awkward 12 to 19 stretch, and an adolescent obesity clinic. Tomi with some admiration writes: "That Dr. Hammar relates well with adolescents is easy to see. Even at first glance, he comes across warm—what with hot pink tie against a cool pink shirt that he wore during the interviews. . . . He laughed: 'I like bright colors. The trend in men's fashion is long overdue. I had to wear a dress shirt the other night. That was the first white shirt I've worn in two years.'"

In a **Lois Taylor** article "Lefties Want Their Rights," **Jimmy Wong**, left-handed Ob-Gyn man, complained, "Needle holders and hemostats have always been manufactured only in the right-handed version. Now the medical supply houses have made a breakthrough with left-handed things, and they're always trying to sell them to me. I guess they don't run into many left-handed surgeons. But it's too late for me. I've taught myself since medical school to use right-handed ones, and I'd have to learn all over again."

Walter Strode, a member of the World Future Society (Hawaii Chapter), spoke on "Revolution in Bio-Medical Science" in the "Come Gods, Let Us Play" series at the University.

Bill Bergin of Hilo was quite perturbed by **Gene Hunter's** story on Silva and wrote: "Hunter's bannerline Silva story is the penultimate in sick journalism. God rest and honor the soul of Fitzjohn. May God forgive Gene for glorifying crime. Silva made her life, not Kakaako. . . ."

OD Pinkerton favors the Fasi proposal for an ordinance citing people for scattering litter. Only, OD hopes that "It will apply equally to the City and County of Honolulu refuse collection men, who leave a path of litter in their wake. . . . You can always tell when the refuse men have serviced certain streets by the litter of papers and garbage which is on the ground or in the street itself due to their careless handling of garbage containers and other items. . . . So it seems to me that the City and County should first take care of their own problem and if the law is passed, serve citations on their own personnel as they would on the ordinary citizen."

Scott Halstead discussed the medical education program in Vietnam sponsored by the US Agency for International Development and the American Medical Association: "There is a revolution in medical care, but our country doesn't seem to see this and is phasing out the Vietnam program before its goal is reached." Scott calls the short term planning and temporary aid "cruelty masked in kindness." About 40 million dollars a year are spent in the health program, but only one million goes

to relevant medical needs, ie, the training of physicians who must provide the medical care. . . .

Linus Pauling, Jr. calls the City Traffic Department's new plan for a Waikiki bypass ridiculous. "In the first place it destroys a large portion of what little open green space is left in ewa Waikiki and lower Moiliili. Secondly, the plan takes traffic into Waikiki instead of around, thereby missing the point and jeopardizing the effectiveness of the new Waikiki Loop plan, which seems successful. . . . The solution lies in the direction of effective, rapid mass transit."

Another environmentalist, **Robert Fisher**, says "I am extremely disturbed by the recent City Council action to permit apartment zoning and thus allow construction of the Makaha Surfside Project. This action by the City Council is yet another step in their seeming goal of destroying whatever is still an open space or green and growing left on Oahu. . . . The adage that government is but a caretaker of the environment for the next generation has continuously been ignored or violated by the Council with this action and other similar decisions. I despair at such representation for us and our children and strongly encourage a vigorous protest by Hawaii's citizens now and at election time."

George "Bill" Starbuck, medical director of the Children's Protective Services Center at Children's Hospital, believes that an erroneous number of sex abuse cases involving children occur in Hawaii, but the bulk of these aren't reported because the subject is taboo. "The cases we know about merely scratch the surface." Such cases include a broad range—from incest, to rape, to that "nice old man in the neighborhood who molests little girls."

Announcements

EIGHTH INTERNATIONAL CONGRESS OF ELECTROENCEPHALOGRAPHY AND CLINICAL NEUROPHYSIOLOGY

To be held in Marseille, France, September 1-7, 1973. The emphasis of the Congress will be on Free Communications. Papers will be selected on the basis of originality and quality. There will also be two EEG Round Tables ("Possibilities and Limitations of New Methods of Data Collection and Analysis"; "Basic Mechanisms of Epilepsy"), two EMG Round Tables ("Computer Analysis of the EMG" and "Histopathology of Nerve and Electrophysiological Correlations") and a Common Session in the "Clinical Neurophysiology of Speech" (including mechanisms of reading and writing). There will also be a concurrent program of didactic lectures and demonstrations (for senior technicians, technologists and clinicians), scientific exhibits and demonstrations, commercial exhibits. The official languages will be French and English. There will be a banquet at the Palace of the Popes at AVIGNON. Inquiries may be directed to the Secretary of the Congress, Mme. le Dr. G. C. LAIRY, Hôpital Henri Rousselle, 1, rue Cabanis, Paris 14^e, France.

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POSTGRADUATE COURSE: SPECIFICALLY TREATABLE DISEASES

Presented by The American College of Physicians, March 20-24, 1972, at the University of Pennsylvania Medical School, Pennsylvania Hospital, Philadelphia, Pennsylvania. For registration, information, and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

TWO PROGRAMS FOR SURGEONS

Presented by UCLA Extension's Continuing Education in Health Sciences and the UCLA School of Medicine, at the El Mirador Hotel in Palm Springs, California. The first program, "A Multidiscipline Symposium Workshop for Physicians on Management of Trauma" will meet from March 22-25, 1972. The second program, "The Ninth Annual UCLA Seminar on Controversial Areas in Surgery" will be held March 25-29, 1972. For additional information write: Elizabeth Gifford, Department of Continuing Education in Health Sciences, University Extension, UCLA, Los Angeles, Calif. 90024.

SEVENTH NATIONAL CANCER CONFERENCE

Sponsored by the American Cancer Society and the National Cancer Institute, September 27-29, 1972 at the Biltmore Hotel, Los Angeles, California. For registration and information write: Sidney L. Arje, M.D., Coordinator, Seventh National Cancer Conference, c/o American Cancer Society, Inc., 219 East 42nd Street, New York, N. Y. 10017.

NATIONAL CONFERENCE ON HUMAN VALUES & CANCER

Sponsored by the American Cancer Society, June 22-24, 1972, Regency Hyatt House, Atlanta, Georgia. For registration and information write: William M. Markel, M.D., National Conference on Human Values & Cancer, c/o American Cancer Society, Inc., 219 East 42nd Street, New York, N. Y. 10017.

POSTGRADUATE COURSE: THE NEW FACE OF PULMONARY DISEASE

Presented by The American College of Physicians, March 27-29, 1972, at The Beverly Hilton, Beverly Hills, California. Co-sponsored by the Continuing Education in Allied Health, University Extension, and the School of Medicine, UCLA, in cooperation with the Tuberculosis and Respiratory Disease Association of Los Angeles County, and the California Thoracic Society. For registration, information, and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

GERIATRICS MEDICAL SOCIETY TO HOLD ANNUAL SCIENTIFIC MEETING

The American Geriatrics Society (AGS) will hold its 29th Annual Meeting, April 5-6, at the American Hotel, New York, N. Y. For registration and information write: Edward Henderson, M.D., Executive Director, American Geriatrics Society, 10 Columbus Circle, New York, N. Y. 10019.

The Tumor Board of Kapiolani Hospital announces the formation of a Trophoblastic Disease Center for the State of Hawaii. Similar centers have been formed in other states. The purpose is to collect and assay information on trophoblastic disease and to be available for consultation to physicians on all the islands. Information can be determined by contacting the secretary of the Tumor Board, Mrs. Lucy Imahiro. Services of the Trophoblastic Disease Center are without charge to patient or physician. All inquiries will be given prompt attention and all efforts will be made to respect the patient-physician relationship. Patients may be sent in for examination and report, or consultations may be requested by letter or phone.

In addition, radioimmune human chorionic gonadotropin assay is being performed by Dr. Stanley N. Oyama, radiochemist of the Department of Nuclear Medicine at the Queen's Medical Center. The specimen required is at least 10 ml of clotted blood. The serum should be separated and refrigerated if immediate delivery is not possible. The optimal sensitivity is 0.02 international units per ml. There is a charge of \$14.00 for each run. However, a certain number of tests will be done free of charge if the request is cleared through the Kapiolani Hospital Tumor Board. The patient may go to the Kapiolani Hospital Pathology Laboratory to have the blood drawn, or refrigerated serum can be mailed in.

The performance of this test, which is the most sensitive available, takes approximately five days and results can be expected within seven days. It is performed weekly, on Tuesday mornings only. The serum should be delivered to Kapiolani Hospital Laboratory at least by Monday afternoon before 4:00 if the results are to be expected the following Tuesday.

COLIN C. MCCORRISTON, M.D.
Chairman, Tumor Board
Kapiolani Hospital
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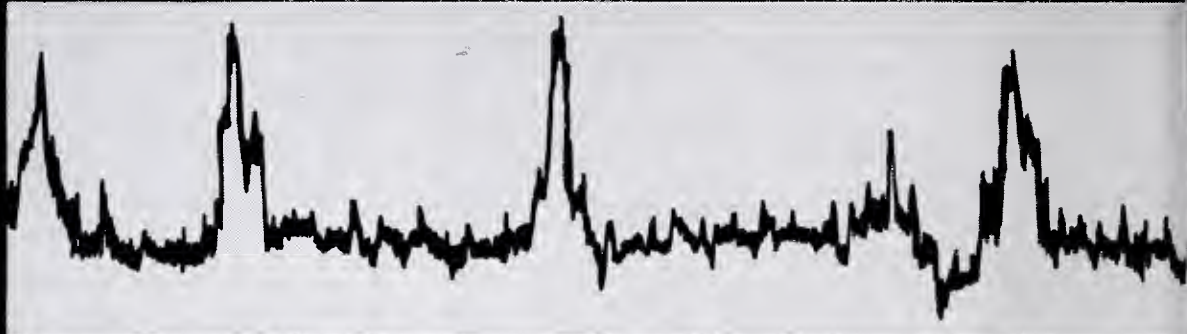
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An intestinal autobiography of rage, contentment and horror*

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"The motility that day was quiet. This type of recording is seen regularly when he is relaxed and contented and the laboratory seems peaceful."*



He was overwhelmed by "paralyzing horror" when told he would need a partial laryngectomy for removal of an early carcinoma; "...the activity of the ileum virtually ceased for over a five-minute period...."*



Background

*Data presented here derive from a 13-year ongoing study by Henry Harrison Sadler, M.D., and Aline Underhill Orten, Ph.D., at Wayne State University. Their findings, which demonstrate a correlation between the emotional state of a human subject and the motility of an isolated segment of his ileum, were published in the April, 1968, *American Journal of Psychiatry*, volume 124, page 1375.

The subject is a 56-year-old man with a 40-cm Thiry loop of ileum created as a result of emergency surgery. A person of modest attainment and simple tastes, the subject depends on the investigators as he might his own family. His full-time job is as a "human laboratory," and throughout the 13-year period of the study, he has taken great personal pride in his own participation.

A story charged with emotion

The graphs on the facing page are intestinal motility readings on a human subject experiencing the emotions of rage, contentment and horror (see "Background" below left). This "intestinal autobiography" dramatizes the point that certain emotions correlate with specific patterns of G.I. motility.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Our "Angels"

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A gratifying announcement about Empirin[®] Compound with Codeine



You may now specify up to five refills within six months when you prescribe Empirin Compound with Codeine (unless restricted by state law).

It is significant in this era of increased regulation, that Empirin Compound with Codeine has been placed in a less restrictive category. You may now wish to consider Empirin with Codeine even more frequently for its predictable analgesia in acute or protracted pain of moderate to severe intensity.

Empirin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. 1/2. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3 1/2, phenacetin gr. 2 1/2, caffeine gr. 1/2.

CC: Pain on Rt. side of face
Dx: Acute purulent bacterial Max. Sinusitis
X-Ray Interp: Waters - Clouding of Rt. Max. Sin.



There are many frustrations in treating acute sinusitis.

Cleocin manages most of the bacterial ones.

Inadequate drainage, chronic rhinitis, allergy, exposure to temperature extremes, and other factors can delay recovery from acute sinusitis.

It's helpful to have an antibiotic like Cleocin HCl (clindamycin HCl hydrate, Upjohn) that can take care of most of the gram-positive bacterial problems related to the disease.

As one study* of 52 outpatients showed, acute maxillary sinusitis was associated with staphylococci in 50% of the group, with pneumococci in 25%, and with streptococci and various other organisms (chiefly gram-negative) in the remainder. Significantly, one-half of these staphylococcal infections were resistant to both penicillin and tetracycline (all were sensitive to erythromycin and chloramphenicol). Although not a part of this study, many other clinical and bacteriologic reports¹ have shown that such gram-positive bacteria, which most often are associated with acute sinusitis, are usually susceptible to Cleocin.

Can be taken before, with, or after meals

The total absorption of Cleocin is virtually unaffected by the presence of food in the GI tract.¹ Cleocin thus can be administered as prescribed without interfering with the patient's mealtimes.

Useful in patients hypersensitive to penicillin

Cleocin's chemical structure bears no relationship to penicillin or the cephalosporins. Cleocin therefore may be especially useful in patients with acute sinusitis who report a history of hypersensitivity to these antibiotics. Although hypersensitivity reactions have been uncommon with Cleocin, it should be used cautiously in atopic individuals. Cleocin is not recommended in the lincomycin-sensitive patient.

Please see following page for further prescribing information.



Cleocin ® 150 mg capsules HCl
clindamycin HCl hydrate, Upjohn

Side effects: In studies of 1,416 patients involving 92 clinical investigators, side effects were reported in 8.2%.¹ Diarrhea or loose stools were noted in 3% of these cases (one patient with bloody stools). In a few instances, diarrhea lasted several days. A slightly higher incidence of diarrhea or loose stools has been reported by some investigators in subsequent studies.



Toxicity: No irreversible hematologic, renal, dermatologic, or neurologic abnormalities have been reported.¹ Transient leukopenia and eosinophilia have been observed. Elevations of alkaline phosphatase and serum transaminases were observed in a few instances. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

In acute sinusitis and other upper respiratory infections due to susceptible staphylococci, streptococci, and pneumococci

Cleocin[®] HCl

clindamycin HCl hydrate, Upjohn

Each preparation contains:

150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin, Upjohn) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Cleocin HCl (clindamycin HCl hydrate) is indicated in infections of the upper and lower respiratory tract, skin and soft tissue, and, adjunctively, dental infections caused by gram-positive organisms which are susceptible to its action, particularly streptococci, pneumococci and staphylococci.

As with all antibiotics, *in vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: Patients previously found to be hypersensitive to this compound or to lincomycin.

WARNINGS: Safety for use in pregnancy not established. Not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. Perform periodic liver function tests and blood counts during prolonged therapy. The serum half-life in patients with markedly reduced renal function is approximately twice that in normal patients; hemodialysis and peritoneal dialysis do not effectively remove Cleocin from the blood. Therefore, with severe renal insufficiency, determine serum levels of clindamycin periodically and decrease the dose appropriately. Should overgrowth of nonsusceptible organisms—particularly yeasts—occur, take appropriate clinically indicated measures.

ADVERSE REACTIONS: Generally well tolerated in clinical efficacy studies. Side effects reported in 8.2% of 1,416 patients. Of the total, 6.9% reported gastrointestinal side effects and 1.3% reported other side effects. Diarrhea or loose stools were reported in 3%. *Gastrointestinal:* Symptoms

included abdominal pain, nausea, vomiting and diarrhea or loose stools. In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. *Hematopoietic:* Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. *Skin and Mucous Membranes:* Skin rash and urticaria have been reported infrequently. *Hypersensitivity Reactions:* A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. *Liver:* Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections—150 to 300 mg every 6 hours. Severe infections—300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections—8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections—16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β -hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

SUPPLIED: 150 mg Capsules—Bottles of 16's and 100's. 75 mg Capsules—Bottles of 16's and 100's. Sensitivity Disks—2 μ g. Sensitivity Powder—Vials.

For additional product information, see your Upjohn representative or consult package insert. MED B-4-S (LNU-3) JA71-1565

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Kamuela, Hawaii

This course consists of a lecture series covering topics of current interest in the field of surgery. Arrival in Hawaii will be on Sunday, April 16, with departure on Sunday, April 23. Lectures will be held Monday through Friday from 9 a.m. to 12 noon, with a panel discussion on Saturday morning.

COURSE OUTLINE

- Emergency Care of Hand Injuries
- Advanced Techniques in Reconstruction of the Hand
- Skin Coverage
- Management of Injuries to the Face
- Organ Transplantation
- G. I. Hemorrhage
- Surgical G. I. Disorders in the Neonate
- Shock
- Cerebral Death
- Extracranial Occlusive Cerebrovascular Disease
- Renovascular Hypertension
- Management of Urinary Tract Infections
- Primary Breast Carcinoma
- Metastatic Breast Carcinoma

Panel Discussion on Trauma

An elective course in medical emergencies in surgical patients also will be available.

FACULTY

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Roy B. Cohn, M.D., Walter Clifford Chidester and Elsa Rodney Chidester Professor of Surgery, Stanford University School of Medicine
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John W. Hanbery, M.D., Professor of Surgery and Head, Division of Neurosurgery, Stanford University School of Medicine
Thomas A. Stamey, M.D., Professor of Surgery and Head, Division of Urology, Stanford University School of Medicine

GENERAL ARRANGEMENTS

Registration: Tuition for the course is \$275 which must accompany the application. Registration is limited to 68 M.D.s and application must be received no later than February 15, 1972.
Hotel: Room reservations for Mauna Kea Beach Hotel will be made through the Office of Postgraduate Medical Education at Stanford and will be confirmed upon receipt of \$100 deposit. (Ocean-view room, 7 nights, double occupancy, Mod. Am. Plan, including cocktail party—\$600)
Travel: Round-trip transportation SFO to Kamuela to SFO at the special group tariff of \$146 (plus tax, excluding airport transfer, and subject to gov't authority) will be arranged through the official travel agent: Leo T. Sides, Leo T. Sides Travel Service, 76 Stanford Shopping Center, Palo Alto, California 94304, (415) 321-1111. The travel service will contact registrants to confirm travel arrangements and coordinate any desired pre- and post-meeting travel.

APPLICATION FORM

POSTGRADUATE COURSE IN SURGERY
April 16-23, 1972

Course Tuition: \$275
Room Deposit: \$100

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Last First Middle
ADDRESS _____
Street City State Zip Code
DAYTIME PHONE _____
MEDICAL SCHOOL _____ Year _____ Specialty _____

Enclosed is \$375 for full tuition and room deposit.

I wish special round-trip group air transportation SFO to Kamuela to SFO.

I am interested in arranging pre- or post-meeting travel (inter-island/Orient/Pacific) with Leo T. Sides Travel Service, Palo Alto, California

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APPLICATION MUST BE RECEIVED BY FEBRUARY 15

Call it what you will, it may be premalignant

Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



MARCH / APRIL 1972

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VOLUME 31 / NUMBER 2

MAY 15 1972





rheumatoid arthritic blowup... Tandearil® Geigy oxyphenbutazone NF

tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

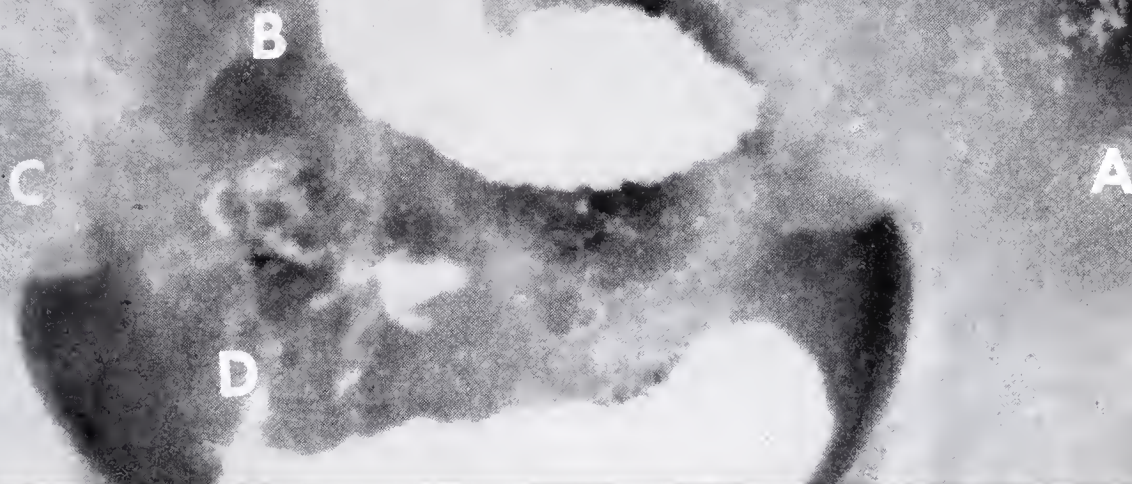
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, enuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B) 98-146-800-E

For complete details, including dosage, please see full prescribing information.

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regional enteritis
or malabsorption syndrome?*



In G.I. disorders
when nutritional supplementation
is indicated

Berocca[®] tablets
is therapy

With balanced, high potency
B-complex and C vitamins.
No odor.
Virtually no aftertaste.
Lowest priced Rx formula.

Please see Complete Prescribing Information, a summary of which follows:

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Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B₁₂.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.



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clumps (B), destruction of the terminal ileal mucosa (C), and fistulation adjoining the terminal ileum (D). There is no thickening of the bowel mucosa or fistulation in malabsorption syndrome.

ALL IN HIS HEAD:

Watery Eyes

Nasal
Congestion

Sneezing

Runny Nose

**THE COLD
SYMPTOMS
THAT
MAKE HIM
MISERABLE**

ALL IN 'ORNADE:

Drying Agent
(isopropamide,
as the iodide—
2.5 mg.)

Decongestant
(phenylpropanol-
amine HCl—50 mg.)

Antihistamine
(chlorpheniramine
maleate—8 mg.)

**THE
INGREDIENTS
HE NEEDS
FOR PROLONGED
RELIEF**

Before prescribing, see complete prescribing information in SK&F literature or PDR.

Indications: Upper respiratory congestion and hypersecretion associated with the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

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Each capsule contains 8 mg. of Teldrin[®] (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide. brand of sustained release capsules

UNCOMMON RELIEF FOR COLD SYMPTOMS

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VOLUME 31, NUMBER 2

MARCH-APRIL, 1972

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LADY WHO CAN
OUTLIVE TWO HUSBANDS
AND SURVIVE
FOUR ROARING SONS,
DESERVES
A GOOD NIGHT'S
SLEEP.

*She's not overly rich.
But she isn't losing any sleep over paying
the bills either. Husband No. 2 took care of
that when he started the trust. |
We managed his income-producing
assets and reinvested the profits.
Later, none of it went through probate.
Or down the drain in needless estate taxes. |
Instead, the trust sent four sons to college.
And enabled a lady who's seen it all
to keep it all. :-*



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HAWAII MEDICAL JOURNAL

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Cover: From the collection of Meryl H. Haber, M.D. An original print from an engraving by W. Hogarth captioned "Don Quixote seizes the Barbers' Bason for Membrine's Helmet."

CC: Pain on Rt. side of face

Dx: Acute purulent bacterial Max. Sinusitis

X-Ray Interp: Waters - Clouding of Rt. Max. Sinu



There are many frustrations in treating acute sinusitis.

Cleocin manages most of the bacterial ones.

Inadequate drainage, chronic rhinitis, allergy, exposure to temperature extremes, and other factors can delay recovery from acute sinusitis.

It's helpful to have an antibiotic like Cleocin HCl (clindamycin HCl hydrate, Upjohn) that can take care of most of the gram-positive bacterial problems related to the disease.

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The total absorption of Cleocin is virtually unaffected by the presence of food in the GI tract.¹ Cleocin thus can be administered as prescribed without interfering with the patient's mealtimes.

Useful in patients hypersensitive to penicillin

Cleocin's chemical structure bears no relationship to penicillin or the cephalosporins. Cleocin therefore may be especially useful in patients with acute sinusitis who report a history of hypersensitivity to these antibiotics. Although hypersensitivity reactions have been uncommon with Cleocin, it should be used cautiously in atopic individuals. Cleocin is not recommended in the lincomycin-sensitive patient.

Please see following page for further prescribing information.



Cleocin HCl ® 150 mg capsules
clindamycin HCl hydrate, Upjohn

Side effects: In studies of 1,416 patients involving 92 clinical investigators, side effects were reported in 8.2%.¹ Diarrhea or loose stools were noted in 3% of these cases (one patient with bloody stools). In a few instances, diarrhea lasted several days. A slightly higher incidence of diarrhea or loose stools has been reported by some investigators in subsequent studies.



Toxicity: No irreversible hematologic, renal, dermatologic, or neurologic abnormalities have been reported.¹ Transient leukopenia and eosinophilia have been observed. Elevations of alkaline phosphatase and serum transaminases were observed in a few instances. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

In acute sinusitis and other upper respiratory infections due to susceptible staphylococci, streptococci, and pneumococci

Cleocin[®] HCl

clindamycin HCl hydrate, Upjohn

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin, Upjohn) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Cleocin HCl (clindamycin HCl hydrate) is indicated in infections of the upper and lower respiratory tract, skin and soft tissue, and, adjunctively, dental infections caused by gram-positive organisms which are susceptible to its action, particularly streptococci, pneumococci and staphylococci.

As with all antibiotics, *in vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: Patients previously found to be hypersensitive to this compound or to lincomycin.

WARNINGS: Safety for use in pregnancy not established. Not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. Perform periodic liver function tests and blood counts during prolonged therapy. The serum half-life in patients with markedly reduced renal function is approximately twice that in normal patients; hemodialysis and peritoneal dialysis do not effectively remove Cleocin from the blood. Therefore, with severe renal insufficiency, determine serum levels of clindamycin periodically and decrease the dose appropriately. Should overgrowth of nonsusceptible organisms—particularly yeasts—occur, take appropriate clinically indicated measures.

ADVERSE REACTIONS: Generally well tolerated in clinical efficacy studies.

Side effects reported in 8.2% of 1,416 patients. Of the total, 6.9% reported gastrointestinal side effects and 1.3% reported other side effects. Diarrhea or loose stools were reported in 3%. *Gastrointestinal:* Symptoms

included abdominal pain, nausea, vomiting and diarrhea or loose stools. In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. *Hematopoietic:* Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. *Skin and Mucous Membranes:* Skin rash and urticaria have been reported infrequently. *Hypersensitivity Reactions:* A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. *Liver:* Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections—150 to 300 mg every 6 hours. Severe infections—300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections—8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections—16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β -hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

SUPPLIED: 150 mg Capsules—Bottles of 16's and 100's. 75 mg Capsules—Bottles of 16's and 100's. *Sensitivity Disks*—2 μ g. *Sensitivity Powder*—Vials. For additional product information, see your Upjohn representative or consult package insert. MED B-4-S (LNU-3) JA71-1565

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The most commonly reported side effects are drowsiness, ataxia, and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation; tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.


Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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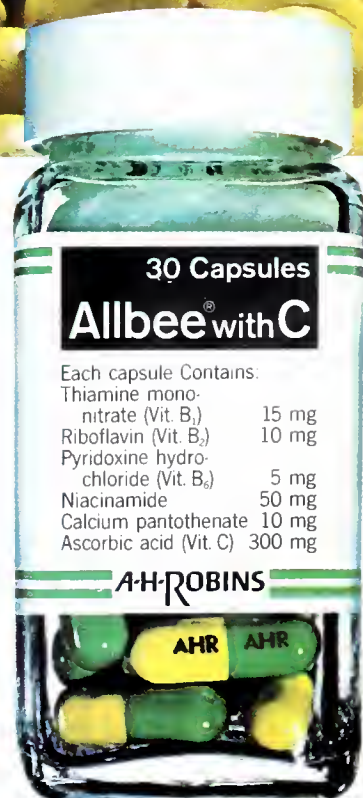
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Brief summary. Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.



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Conference Report

Second National Conference on Breast Cancer

Los Angeles, California, May 17-19, 1971

JOHN F. BALFOUR, M.D., *Honolulu*

THE SECOND National Conference on Breast Cancer, held under the auspices of the American Cancer Society was held to exchange information concerning this disease gained since the First National Conference in 1969.

INCIDENCE

Among the women in the United States, the breast is the leading site of cancer in both incidence and mortality. In the United States one woman dies of breast cancer every 20 minutes. Dr. Sidney J. Culter of the National Cancer Institute presented data showing that although there has been a slight decrease in the age-adjusted mortality rates for breast cancer, attributable to earlier diagnosis and treatment, there has been a concomitant increase in the incidence of breast cancer in premenopausal women, which is counterbalancing the better results.

Of interest has been the observed low rate of breast cancer in the Japanese women living in Japan, a difference more pronounced in postmenopausal women than premenopausal. Japanese women who migrate to Hawaii and the continental United States, and their American-born daughters, show some increase in rates over the home country. However, the rates remain closer to those of the home country than to those of the host country. It has been suggested by several investigators that dietary factors have contributed to the increases that did take place by affecting endogenous hormones. Not only is the rate of breast cancer lower in Japanese women; their survival rates are also substantially better.

Endocrine

Recent studies emphasize the importance of age

at first full term pregnancy with respect to the risk of breast cancer. Women with first birth after age 35 had triple the risk of those with first births before age 18; at least up to age 30, the risk increases linearly with increase in age at first birth.

Previous studies emphasized the decreased risk of breast cancer in multiparous women. The new studies show that the primary association is between breast cancer and age at first pregnancy, and that the association between breast cancer and parity is secondary.

Partly on the basis of the importance of age at first pregnancy with respect to breast cancer risk, Cole and MacMahon hypothesized that the relative levels of the estrogen fractions, estrone, estradiol, and estriol, produced between puberty and age 25, are crucial determinants of a woman's lifetime breast cancer risk.

Hormonal influence on breast cancer is also emphasized by the fact that artificial menopause reduces the risk of breast carcinoma by about 50-60%. Also, women with a natural menopause at 50 years and over had 1.4-1.7 times the risk of those with natural menopause under 45.

The protective influence of prolonged lactation induced by nursing on the development of breast carcinoma has been overemphasized in the past.

The breast cancer risk in women with chronic cystic mastitis is 2.64 times that of women in general.

Bulbrook, from Edinburgh, has observed a strong correlation between low urinary androsterone and aetiocholanolone levels and breast carcinoma. Sisters of patients with breast carcinoma have double the risk of developing carcinoma and tend to show the same abnormal urinary excretion pattern. Japanese women, who have a low incidence of breast carcinoma, have been found to

From the Department of Surgery, Straub Clinic.
Received for publication July 15, 1971.

excrete significantly greater levels of androsterone and aetiocholanolone than British women.

VIROLOGIC STUDIES

Dr. William F. Feller of Georgetown University has demonstrated in human milk, by electron microscopy, particles which resemble at least one of three oncogenic viruses in animals. The three animal viruses are Beta particles, which are known to cause breast cancer in mice; C particles, which are known to cause leukemia and sarcoma in mice; and monkey mammary virus particles, which are suspected of causing breast cancer in this species. The human, monkey, and mouse viruses all have RNA-dependent DNA ploymerase, believed to be important in oncogenesis.

The incidence of these particles being demonstrated in normal lactating women is only 4-5%, while it is present in 45% of the women with near female relatives with breast carcinoma, and 50% of lactating women who themselves have had breast cancer. These studies have been confirmed by Dr. Leon Dmochowski of M. D. Anderson Hospital, and Dr. Dan Moore of the Institute for Medical Research in Camden, New Jersey.

The question comes up: Are these particles in human milk, which are seen by electron microscopy, really viruses? There are three criteria for judging this, according to Dr. Feller: (1) They should show infectivity, (2) They should show budding by electron microscopy, and (3) They should demonstrate RNA-dependent DNA polymerase. As yet, only the third criterion has been demonstrated. Some investigators feel chemistry may be more successful in detection than the identification of virus particles by electron microscopy.

Koch's postulates for mammary carcinoma in mice have been satisfied: that is, Beta particles have been inoculated into newborn mice, causing the incidence of breast cancer to rise from a normal of 2% to 90%.

Obviously, this cannot be done in humans, but valuable though admittedly indirect epidemiological evidence may be gained by demonstrating "secreters" and "nonsecreters" of these particles in lactating women, and then following them for the development of breast cancer.

Dr. Eugene Edynak from the University of Pennsylvania demonstrated two new antigens which develop in cancer of the breast but which are not present in normal tissue or in tissue harboring other diseases. These antigens can be demonstrated in the first two trimesters of pregnancy, then disappear. It is felt, therefore, that they are

the product of a "primed cell," a form of derepressive dedifferentiation. This may account for the high degree of multifocal disease now being demonstrated in serial sections of breasts containing cancers. Of interest, the antigens can be demonstrated in histologically negative breast tissue taken from a breast containing a cancer, indicating that there is a whole-organ antigen change. In addition, the antigen can be demonstrated in a high percentage of contralateral breasts in women harboring breast carcinoma, and in metastases as well, but not in tissue adjacent to metastases.

THERAPY

While the best mode of primary surgical therapy for breast carcinoma was much discussed, there can be no doubt about the effectiveness of adequate local removal.

Thus, Bloom showed that the relative survival rates at 10 years for surgically treated cases were far superior to those in cases receiving no surgery, regardless of histologic grade of the malignancy. The relative 10-year survival rate for Grade I malignancy with no surgical treatment was 18%, versus 64% for surgically treated cases. For Grade II cases, the figures were 3% versus 38%, and for Grade III cases, 0% versus 22%, respectively.

The problem with the myriad of studies that have been presented in literature, whether their authors be proponents of supradradical, radical, modified radical, or simple mastectomy plus x-ray therapy to the axillary lymph nodes, is that they fail to compare like cases. Histologic type, lymph node involvement, host immune data, tumor size, race, age, *et cetera*, will all significantly affect the overall statistics. If all such variables were taken into account, the number of cases needed to prove any possible small differences in efficacy of one surgical procedure over another would be prohibitively large for any single group of investigators.

In an attempt to circumvent this problem of numbers, a multi-institutional cooperative study has been set up in an effort to determine which form of primary surgical treatment is best. This should provide thousands of cases for review, matching, and comparison.

Although such a study is long overdue, most investigators and statisticians believe any possible differences which might be shown would be very small indeed, for the following reasons: Adequate local treatment will cure the disease if it has not already become systemic. Breast cancer is a disease which rarely, if ever, is responsible for death by its local effect; it kills by metastatic spread.

Limited improvement in local treatment cannot alter the survival rate much. Under such circumstances, one can expect very little if any difference in end results in terms of survival when comparing treatment methods designed primarily for local control.

More recently Dr. George Crile, of the Cleveland Clinic, has advocated simple mastectomy or segmental removal of the tumor, with preservation of the axillary lymph nodes if the lymph nodes are *clinically* judged negative for metastatic involvement. He believes that removal of the axillary lymph nodes may interfere with development of host resistance.

There seems to be several serious loopholes in this theory. First, it is well known that there is substantial disagreement between the clinical and pathological evaluation of axillary lymph nodes. Nearly one-third of all clinically negative cases end up being pathologically positive, while one-third of clinically positive cases end up being pathologically negative.

Does local lymph node extirpation have a deleterious effect on host resistance? Experimental evidence indicates that sensitized lymphoid cells leave the nodes within hours or at most a few days following antigen stimulation, by which time the immune response has almost certainly become generalized.

Since the doubling time for human breast cancer may vary from 20 to over 200 days, it can be calculated that the time required for a tumor to reach only 1 cm in diameter, based on 30 doublings, may vary from 23 months to 17 years. Consequently, when a patient with breast cancer presents herself for medical advice, the tumor has probably been present for at least one year, during which time any immunologic response against the tumor should certainly have become fully mounted and systemic; indeed, such a response may be declining or may be completely exhausted as a result of the increased tumor activity.

How, at this late state of tumor development, can local irradiation or surgical ablation of the regional nodes prevent or depress an immune response against cancer to a degree which proves harmful to the host? Dr. Sidney J. Culter drew attention to the superior survival of women with breast cancer treated by radical mastectomy in whom bilateral axillary nodes were palpable. This applied whether the homolateral nodes were histologically involved or not. Enlargement of negative nodes in these cases appeared to be related to considerable sinus histiocytosis, a histologic

manifestation of host resistance. Dr. Culter suggested that the contralateral node involvement is due to a systemic host reaction.

EARLY DETECTION

It seems the real thrust should be directed toward areas which will *significantly* lower the mortality rate from this disease. One may postulate from survival data that over half of the women with breast cancer have systemic (though undetectable) disease by the time they first present for treatment. If so, the real investigative thrust should be toward both earlier detection and development of more effective adjunctive systemic treatment to accompany surgery.

The use of simple, routine annual physical examination for the detection of breast cancer has yielded impressive results. Such a study was reported by Dr. Victor A. Gilbertsen of the University of Minnesota Cancer Detection Center. Since 1948, among more than 8,000 women—45 years or older at intake—who have undergone more than 46,000 annual examination, 104 breast cancers have been detected, 60% at annual examinations, 40% between examinations, usually by the women themselves. Of these women, 70% had axillary lymph nodes free from metastatic disease, as compared with the usual 45-50%.

To evaluate mortality results, the technique of the National Cancer Institutes End Results Study was employed: that is, the survival of the patient group was measured against the expected survival of an equal number of women of the same age in the general population. In the overall experience, the observed survival of women in the study with breast cancer was 88% as compared with 92% expected at five years, a relative survival of 96%; at 10 years, observed survival was 78% as against an 81% expectation, so that the relative survival remained at 96%; at 15 years, the cancer patients had a 73% survival while the expected survival was 67%, so that the relative survival actually exceeded 100%. These 5, 10, and 15 year relative survival rates of 96%, 96%, and 100% compare quite favorably with respective figures for overall breast cancer in the United States which are 63%, 50%, and 43% respectively.

Several studies are now going on to evaluate the effectiveness of adding thermography and mammography to annual physical examinations. Dr. Robert L. Egan of Emory University, a long time proponent of mammography, noted that 10% of the breast cancer seen in his institution on soft tissue x-ray are clinically unsuspected, and 92%

of these women have negative axillary lymph nodes on pathological examination.

The expense makes mammography impractical as a mass screening procedure. Identification of the high-risk group would greatly alleviate this serious objection. Dr. George P. Rosemond of Temple University listed the following high-risk criteria, based on accumulated statistics: (1) Previous removal of one breast for cancer, especially for a lobular carcinoma, (2) a strong family history of breast carcinoma, (3) signs and symptoms suggestive of hyperactive ductal epithelium, (4) scattered areas of lumpiness in the breast, (5) a positive mammogram, and (6) perhaps a positive thermogram.

ADJUNCTIVE THERAPY

Thus, efforts directed towards discovering breast carcinoma before lymph node metastasis develops seem well justified, since adequate primary surgical therapy can cure practically 100% of these women. On the other hand, since practically all women treated with surgery only, who are found to have more than four positive lymph nodes, succumb to their disease, some form of adjunctive therapy needs to be developed. The initial clinical trials of thiopeta as an adjunct to surgery failed to show any benefit. However, Dr. Howard Skipper of the Southern Research Institute in Birmingham, Alabama, stated these studies were poorly set up; neither the drug, the schedule, nor the dosage was optimal.

He felt drug therapy applied properly and early could be very effective in killing any small viable tumor clones which may be present after surgery. He pointed out that anticancer drugs work by destroying cells at various stages of division, and are least effective against the cells in the resting state. As malignant disease advances the doubling time of cells increases, so that cell division occurs less frequently, thus reducing the chance that drugs will be effective.

Dr. Irwin Bross, Director of Biostatistics at Roswell Park Memorial Institute, pointed out that since statistics indicate a high percentage of women found to have over four positive lymph nodes probably have systemic disease, the best chance of controlling this occult disease is immediately after surgery, with adjunctive chemotherapy. He stated that results of the effectiveness of this type of therapy would be known in 18 months, since a large percentage of the women in this group normally manifest metastases within this period of time. Most investigators believe treatment with a combination of chemotherapeutic agents as opposed to single agents would offer

better results in adjunctive treatment, just as they have in treating known metastatic breast cancer and other malignancies as well.

TREATMENT OF METASTATIC DISEASE

As mentioned previously, in the treatment of metastatic breast cancer, combination chemotherapy seems to be offering encouraging results both in response rate and probably in overall survival. The response rate to Dr. Richard G. Cooper's five-drug regimen has ranged between 50 and 80%, as opposed to the 30% response rate with other standard therapeutic modalities.

The response to adrenalectomy and hypophysectomy has been dramatic and long lasting when it occurs, but the rate of response in the general population of women harboring metastatic disease has been discouragingly low (less than 30% in unselected series). Because of this, and the magnitude of these procedures, many surgeons have been reluctant to recommend them. Dr. Rita M. Kelly of Harvard Medical School talked about several biochemical tests designed to select the women most likely to respond to hormonal manipulation. Certain biochemical determinants measuring fractional steroid output in the urine, as well as the demonstration of estrogen binding by certain tumors, show promise of selecting in advance the women who will benefit from such ablative procedures.

Dr. Charles B. Wilson, Professor of Neurosurgery at the University of California, discussed the technique of cryohypophysectomy. The procedure is done under local anesthesia and takes only 1-1½ hours to perform. The patient is able to leave the hospital in a few days. While the technique is new and tricky, its obvious advantages seem well worth the efforts necessary to master and perfect it.

SUMMARY

Clearly the cure rates for breast cancer can be greatly enhanced by earlier detection and treatment. The use of simple annual physical examination has proven merit. The ability to pick out high risk populations is now possible. The use of improved techniques in the field of mammography, thermography, hormone studies and virology studies will add to the yield.

More effective forms of adjunctive chemotherapy and immunotherapy should add greatly to the lives saved and quality of years lived by women who have more advanced forms of the disease when first detected.

As with all forms of chronic disease, quite a few years will have elapsed to realize advances already known and which are being applied.

Irritating, but not dangerous—so far.

Crown-of-Thorns Starfish Wounds—Some Observations on Injury Sites

CHARLES B. ODOM, M.D.,[†] and
EDWARD A. FISCHERMANN, B.A.,* *Honolulu*

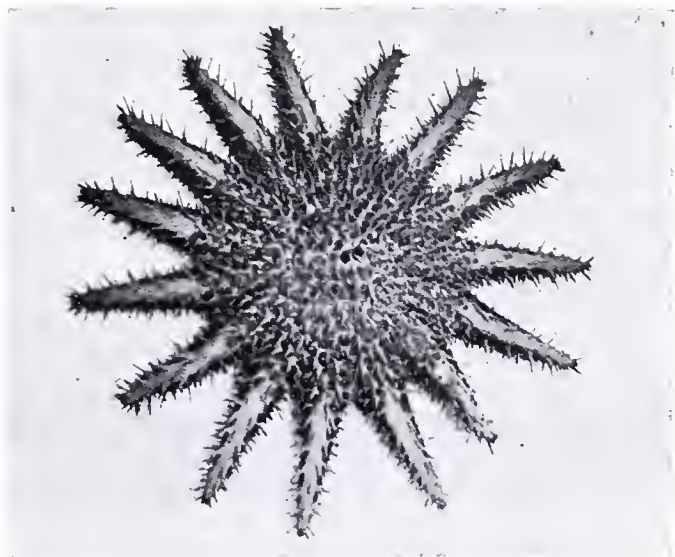
Wounds inflicted by ACANTHASTER PLANCI, the "crown of thorns" starfish, on a scientific party studying ecologic parameters of the starfish population generally involved the extremities. The wounds progressed through an acute state, characterized by local burning sensation and cyanosis, to edema and spreading erythema within 4-6 hours. Several centimeters of tissue around the wound site became involved and the pain became a dull ache. This subacute stage was followed by resolution over the next 24-48 hours. The toxin may contain some anticoagulant properties and may have some systemic effects, evidenced by lassitude and irritability. Though seldom more than a minor inconvenience, such a wound could potentially be a significant health threat with anaphylaxis.

THE PUBLICATION of reports from the western Pacific^{1, 2, 3, 4, 5} of "population explosions" of *Acanthaster planci* (Linnaeus, 1758) and reef destruction attributed to them has focused considerable attention on this marine species.

The toxicity of *A. planci*^{6, 7} is well documented. The following observations were made on victims who sustained their wounds during a study and collecting expedition made off the island of Molokai. The scientific party, with the exception of the authors, were members of the Departments of Zoology and Oceanography, University of Hawaii. The purpose of the trip was to study the ecological

parameters of a concentration of the starfishes discovered at this location.

FIG. 1.—*ACANTHASTER PLANCI*. Photo courtesy of Dr. Joseph Branham, University of Hawaii, Department of Zoology.



NEEDLE-SHARP SPINES

This starfish has an impressive array of thorny spines radiating predominantly from its aboral upper surface. The aboral aspect of the animal is covered by a green to green-red-purple epidermis, containing microscopic glomals which secrete a slimy mucoid substance. The epidermis covers the spines almost to their very tips. Some needle sharp, the spines are 1-5 cm, with an elongated conical shape, and are composed of a dense calcitic cortex and a less dense medullary pulp. The spines break rather easily. However, if they are fractured near their base, the epidermal covering is strong enough to allow the spine to remain attached to the starfish.

From University of Hawaii School of Medicine.

* Second Year Medical Student.

[†] Associate Professor of Obstetrics & Gynecology, Department of Obstetrics and Gynecology.

Received for publication June 4, 1971.

The spines seem to be of a defensive nature only: the victim or an outside agent (such as gravity) must supply the force sufficient for penetration. Injury results from one or several spines puncturing the victim's skin. It is possible to handle the animal without gloves and not sustain injury if one is extremely cautious, but as some of the spines are quite sharp, only light pressure is required for an occasional penetrating wound to occur. The spines are sharp enough to penetrate through leather gloves, clothing, or wet suits.

The most frequent sites of injury to humans are the hands, forearms, and lower legs and feet. The immediate sensation is one of acute burning pain at the site of injury.

Within minutes following the puncture, a bluish discoloration appears, and may extend as much as five to ten millimeters radially around the puncture site. This is followed during the next 4 to 6 hours by a widening area of erythema and edema which may extend in some sensitive individuals for several centimeters about the wound site. The pain changes during this time from the acute burning sensation to a dull uncomfortable ache. Most pain disappears within a few hours after injury, though the wound site is still tender.

Approximately 24 hours after injury, most victims will have a wound area several centimeters in diameter, swollen and slightly red. Perhaps because of the edema there is a sensation of numbness. The edema and numbness gradually resolve during the next 12 to 24 hours. Generally, by 48 hours it is difficult to distinguish the injury site from the surrounding normal tissue.

Some victims seem more sensitive than others, and further, the qualitative and quantitative properties of the toxin(s) of a particular *A. planci* may vary so that the spectrum of response may be foreshortened or prolonged. In addition, the toxin probably has some anti-coagulant property, as wounds bleed more freely and for a greater length of time than would be anticipated, based on the puncture size alone.

There appeared to be some systemic effects from the toxin, based on the observation that some victims suffered from an unexplained lassitude and general "not quite up to par" feeling. However, this observation may have been coincidental in the individuals observed, and bears further critical study.

The spines, being brittle, if a portion should break off in the depths of the puncture wound, it should be removed so that it does not serve as a nidus for abscess formation.

SCRATCH TESTS

In further preliminary clinical study, "scratch tests" were done on three volunteers. Spines which had been snipped from a living *A. planci*; slime from the spines, and slime from the dorsal aspect of the central disc between the spines were tested.

Results: The spines were so brittle that the epidermis on the backs of the volunteers could not be broken by a scratching motion before the spine itself fractured. The skin of one volunteer was punctured with the spine rather than scratched. He suffered a small, attenuated but definite reaction of the type previously described in this report. The other two had no observed reactions. The slime from *A. planci* was applied by means of a sterile needle to the epidermis, which had been scratched to a depth sufficient to cause capillary bleeding. In none of the volunteers was a significant reaction produced by this technique.

SUMMARY

It would appear that *A. planci* produces a toxin which is probably neurotoxic in nature, has anti-coagulatory properties and is injected into the victim by puncture with its spines. The human victim suffers an acute burning sensation at the injured site, annoying and inconvenient. Some very sensitive individuals may have systemic toxic effects. Severe anaphylactic reaction is also a hypothetical possibility.

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Deep leg vein thrombosis and pulmonary embolism cannot be diagnosed clinically in three cases out of four. You need a scan!

Pulmonary Embolism in Deep Leg Vein Thrombosis

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The clinical importance of the frequency of significant but unrecognized pulmonary embolism has been repeatedly stressed, with embolism being one of the commonest causes of death in hospitalized patients.¹ However, in spite of these profound medical implications, the correct ante mortem diagnosis is made in only about one-half of the cases.² The vast majority of patients with pulmonary embolism do not die, however, so that postmortem correlation of emboli with ante mortem symptoms cannot be made in more than a fraction of the total group of patients with this disease.

ATTEMPTS TO demonstrate the presence (or, equally important, the absence) of pulmonary embolism have generally depended upon surveys of patients who are suspected of having embolic disease—particularly with respect to those having measurable abnormalities. The signal that triggers a diagnostic evaluation, therefore, requires some clinical suggestion that an embolism may have occurred or that some relevant laboratory study is abnormal, and usually unexplained. That many emboli occur without symptoms or diagnostic indications before a fatal embolism, much less than before one which is nonfatal or even clinically unimportant, indicates that a diagnostic program geared to symptoms, or clinical suspicion, or laboratory deviations, is grossly inadequate.

There is some urgency to develop a relatively reliable and simple approach to evaluate the occurrence of any pulmonary emboli, whether or not they are physiologically deranging, since their presence alters the therapeutic approach and exigency of treatment.

That pulmonary emboli frequently come from thrombosis in the leg veins, and that even large and lethal emboli can occur without any premonitory signs or symptoms in the legs, is well known.³ In autopsy studies, there has been poor ante mortem prediction of deep vein thrombosis by means of the classical signs of tenderness and Homan's sign, but the presence of ankle edema has proved to have a rather high positive correlation.⁴ The clinical diagnosis of deep vein thrombosis of the leg, therefore, offers considerably more potential in categorizing those patients who are candidates for pulmonary emboli than the current, usual method of waiting for the signs or symptoms of embolism to present.

The most reliable procedure for confirming the diagnosis of deep vein thrombosis available for routine clinical application is venography. Fortunately, this study is also relatively safe and uncomplicated, but it does require some clinical suspicion of thrombosis.

The study being reported is a prospective one, undertaken to evaluate the incidence of pulmonary embolism in patients who have had deep vein thrombosis of the leg established by venography. Signs, symptoms or laboratory studies traditionally associated with embolic disease were specifically excluded as determinants for inclusion in the study.

The reliability of the method used in this study to detect the presence of pulmonary embolism is confirmed by another recently published study which found that perfusion lung scanning is one of the most sensitive tests available for routine clinical use when compared to selective pulmonary arteriography.⁵

Patients who were thought on any clinical grounds to have possible thrombosis of the deep veins of the legs and were referred for venography were included in this study if the venography established the diagnosis of thrombosis. The technique used for the venography is basically that

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described by Wesolowski⁶ with the additional use of image intensification and spot radiographs to define the involved areas. Interpretation of the study depended upon the demonstration of ghosts caused by the thrombosis within the vein.

Once the diagnosis of thrombosis was established, the patients were hospitalized until reliable anticoagulation with coumadin was achieved and any acute signs and symptoms of the phlebitis had subsided. Initial therapy also included bed rest, elevation of the affected leg, elastic support and initial anticoagulation with heparin.

A perfusion lung scan was performed in four projections using ¹¹³¹ labeled macroaggregates of human serum albumin as described by Wagner and others^{8, 9, 10} as soon as possible after the diagnosis of thrombosis was made and at weekly intervals thereafter for as long as the patients were hospitalized. Follow-up perfusion lung scans were obtained on an out-patient basis whenever possible if any abnormalities were noted on the scans during the hospitalization period.

In addition, chest x-rays were obtained concurrently with the lung scans and were independently interpreted by a radiologist. The lung scans were interpreted separately by two of us on two separate occasions before the final result of the scans was recorded. Serial determinations of the serum SGOT, LDH and bilirubin were performed early in the study, but it soon became apparent that the sensitivity of these studies in relation to asymptomatic pulmonary emboli was too low to be of any value.

The 34 patients comprising this study ranged in age from 18 to 85 years and were of multiple racial extraction, characteristic of the heritage of those living in Hawaii. There were 13 men and 21 women with both groups having the same mean age of 56.

There was nearly even distribution of deep vein thrombosis of the legs with 16 appearing on the right and 18 on the left. Obesity as defined by a weight of more than 30 pounds over the ideal weight based on height was present in only five of the patients and, therefore, did not seem to be a significant factor in the presence of thrombosis. Thirteen of the 34 patients had no discernible coexisting condition or reasonable precipitating cause of the thrombosis.

Although there is no way to compare this group with the general population, it is of interest to note that seven of the patients had been involved with prolonged air travel immediately preceding the onset of the thrombosis, two of the women had

been taking oral contraceptives, ten patients had associated local trauma from injury or surgery and ten patients had a past history of probable or definite phlebitis.

The deep vein thrombosis was heralded by swelling of the extremity in 24 patients, pain of the extremity in 13 and only infrequently by tenderness, color change and heat. Symptoms suggestive of pulmonary embolism led to venography and demonstration of the thrombosis in four patients who had no complaints referable to their extremities.

Signs and symptoms specifically elicited once the diagnosis of the thrombosis had been made included swelling of the extremity in 30 patients, pain in the extremity or tenderness to palpation in 23 patients, tightness of the calf in 22 patients, appreciable local heat in 13 patients and a positive Homan's Sign in only 12 patients.

The diagnosis of pulmonary embolism was made on the basis of demonstration of a significant interference in the perfusion of a portion of the lung at least equivalent in extent to a pulmonary segment. The additional requirement was made that any perfusion abnormality had to show change on serial scans to be considered a positive result. The lung scan shown in Figure 1 is typical of one that would be considered abnormal with decreased perfusion to the right upper lobe on the initial scan with complete return of demonstrable blood flow in three weeks.



FIGURE 1.

Using these criteria, there were 17 of the 34 venogram proven cases of deep vein thrombosis of the leg who had a significant and changing interference with their pulmonary blood flow which could only be explained on the basis of embolic disease.

The concurrent chest x-rays were reported as abnormal and suggestive of a possible pulmonary

embolism in 10 of the 17 patients with positive lung scans and in 8 of those 17 who had negative lung scans. Determinations of the serum SGOT, LDH and bilirubin were abnormal in only 1 of 8 patients with pulmonary embolism as defined by the lung scan.

There were no deaths in this series of cases, and embolization was successfully controlled by anticoagulation, vein ligation, thrombectomy and in one case, vena cava clamping.

Symptoms referable to the cardiovascular or pulmonary system, the location of the phlebitis and changes in the vital signs were poor predictors for the presence of pulmonary embolism as detected by the perfusion lung scan. There were, for example, only 4 of the 17 patients with demonstrated emboli who had any chest symptoms which could reasonably be ascribed to the emboli.

SUMMARY

In conclusion, pulmonary embolism as detected by perfusion lung scanning is far more common in seemingly uncomplicated cases of deep vein thrombosis of the leg than would be suspected by signs, symptoms or the usual laboratory and x-ray methods of evaluation for embolic disease. Routine evaluation for pulmonary emboli should be seriously considered in all cases of deep vein thrombosis of the leg, with perfusion lung scanning being one of the simplest and most reliable studies available.

Fifty percent of the cases in this series of deep vein thrombosis had demonstrable pulmonary emboli and more than three-fourths of those with the emboli were asymptomatic. Many of these asymptomatic pulmonary emboli may be harbingers of more serious embolization.

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*While I can understand the patient falling
in love with the nurse, I do not as easily
comprehend the nurse falling in love with
the sick patient.*

SILAS WEIR MITCHELL, M.D.

Shopping can be a pleasure—when one is not “exhausted”!

Air Pollution and Health at Ala Moana Shopping Center in Honolulu

“There is no doubt that air pollution is a contributing factor to the rising incidence of chronic respiratory diseases—lung cancer, emphysema, and asthma.”¹

WILFRID BACH, Ph.D., and KENNETH LENNON, B.S., *Honolulu*

In November, 1970 a series of measurements of carbon monoxide and suspended particulate matter was conducted at the Ala Moana Shopping Center in Honolulu. During the evening peak shopping hours, automobile exhausts raised the pollution level to 47 ppm of carbon monoxide and 280 $\mu\text{g}/\text{m}^3$ of suspended particulates. These values are equivalent to polluted mainland city conditions. The symptoms of increased levels of carboxyhemoglobin in the blood in different groups of people and the potential adverse health effects are discussed. The toxic effects of aerosol inhalation, which may lead to pneumoconiosis are presented. Suggestions for avoiding excessive exposure to harmful substances are made.

IT HAS LONG BEEN suspected that air pollution might be a contributing factor to increasing morbidity and mortality rates in urban areas. Only recently, however, have statistical analyses of hospitalization trends and mortality rates been coupled with air quality measurements to yield the type of information that has prompted Schimmel and Greenburg to attribute 12% of all deaths occurring in New York City between 1963 and 1968 to air pollution alone.²

Ala Moana Shopping Center, one of the largest such centers in the U.S., is in an urbanized area between downtown Honolulu and Waikiki. Because the shopping center is located in the lee of some massive buildings and is oriented perpendicular to the predominant wind direction, some areas are deprived of the natural ventilation provided to other locations on the island by the fairly consistent trade winds. This lack of ventilation is particularly evident in the evening when the absence of thermally-induced air flow allows high air pollu-

tion concentrations to build up in those locations where traffic is heaviest.

The multi-level parking areas which nearly surround the two level central core of retail stores provide about 7800 parking stalls. Only 43% of these parking stalls are in the open air; the remaining 57% are covered over by concrete ceilings. The nearly one million automobiles that enter and leave the shopping center each month contain an average of 2.7 shoppers each. From this it can be estimated that almost 100,000 people frequent the shopping center on an average day. The generally helpful administration office of the Center was not able to provide information concerning the number of shoppers frequenting the Center at different hours of the day, but estimates ascertained with some assistance from sales personnel suggest that 10% of these people shop between 10 a.m. and noon, 25% between noon and 1:30 p.m., 15% between 1:30 and 6 p.m., and 50% between 6 and 9 p.m. From these estimates, it was decided that sampling should be carried out during the 6 to 9 p.m. peak shopping hours, with additional samplings from 9:30 to 10:30 p.m. to obtain contrasting values after all the shops had closed. As a sidelight, it appears that the busiest shopping days are, in order, Saturdays, Fridays, Mondays, and Sundays.

Of the six atmospheric pollutants currently being regulated by law, carbon monoxide and suspended particulates were chosen as the air pollution constituents to be sampled in this study. In the shopping center, carbon monoxide would originate almost exclusively from automotive exhausts, while particulates could stem from either automotive exhausts and tire wear or blowing dust. Either of these pollutants is capable of creating serious impairments to the health and welfare of people who shop or work at the Ala Moana Shopping Center.

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The major objectives of this study were: 1) to obtain quantitative measurements of the pollution concentrations encountered by people on the sidewalks and in the parking areas of the Ala Moana Shopping Center, and 2) to present information concerning the adverse health effects that concentrations of air pollutants at the levels measured might cause.

EXPERIMENTAL DESIGN

The sampling network was designed so that measurements in areas with the highest pedestrian traffic would be obtained. Thus the sub-street and fourth level parking areas were not sampled since these areas are primarily for employee and occasional overflow parking.

An integrating nephelometer was used to measure suspended particulates. This sampling instrument consists of three main components: 1) the optical tube, 2) the pump assembly, and 3) the electronic module. Ambient air is drawn into the optical tube at constant humidity by the pump assembly at a rate of 100 liters per minute. A xenon flash lamp emits pulses of diffuse light into the optical tube at regular intervals. Part of this light is scattered by aerosols in the parcel of air being sampled, and a photomultiplier converts the electromagnetic radiation of this scattered light into an electrical signal which is then transmitted to the electronic module for readout on a meter or a strip-chart recorder. The magnitude of the signal is proportional to a back-scattering coefficient, a measure of that part of the attenuation of a light beam that can be attributed to scattering in a backward direction. The relative recording accuracy of the nephelometer is 2 to 5%. The instrument can be used to obtain continuous recordings at a stationary site or, because of its nearly instantaneous response, for mobile sampling, as was done here, by mounting the instrument in an automobile.

It has been shown that values of back-scattering coefficient thus measured can be related to the mass concentration of suspended particulates (M) by the following relation: $M = K \cdot b_s$ ($\mu\text{g}/\text{m}^3$) where b_s is the back-scattering coefficient and K is an empirical constant of proportionality. For 90% of the observed cases $K = 0.38 \times 10^6$. While this relation might be sufficiently accurate for many routine pollution sampling situations, it was decided that for the purposes of this study it would be better to present the results in terms of a suspended particulate pollution index b_s/b_r where b_r (the Rayleigh coefficient) is the scattering coefficient

of air molecules alone, ie, of air that is particulate-free. At sea level $b_r = 0.23 \times 10^{-4}$. Thus the dimensionless index $b_s/0.23 \times 10^{-4}$ gives a measure of the relative importance of the scattering by man-made suspended particulates at the Ala Moana Center.

Using the mass concentration relation described above the particulate pollution indices of < 4.0 , $4.0 - 10.0$, and > 10.0 shown in Figs. 1 A-D correspond to suspended particulate concentrations of < 35 , $35-87$, and $> 87 \mu\text{g}/\text{m}^3$, respectively.

Carbon monoxide measurements were obtained, utilizing a battery operated sampling pump and colorimetric tubes chemically selective to carbon monoxide. Air being sampled was drawn through a tube at a known flow rate for a measured length of time. The concentration of carbon monoxide in the sampled air is determined by measuring the length of the discolored zone and referring to the manufacturer's pre-calculated calibration chart to ascertain the concentration in parts per million. Although the data obtained utilizing this method are not as accurate as data found by using the more cumbersome and expensive non-dispersive infrared spectroscopic method suggested by the Environmental Protection Agency, it was deemed suitable for a study of this nature.

Individual carbon monoxide measurements were taken at a variety of sidewalk sites on both levels of the shopping center during those previously mentioned time periods when mobile particulate sampling was being conducted.

On the seven sampling evenings in mid-November, 1970, a 45-minute mobile sampling route, including 73 reference sites on the street level and 62 sites on the mall level, was traversed once during the peak evening shopping hour (7:45 to 8:45 p.m.) and once again at a time after all the shops had closed (9:30 to 10:30 p.m.).

DISCUSSION OF RESULTS

Figures 1 A-D show suspended particulate pollution patterns for a typical evening in November, 1970. The concentrations presented represent values collected for each site during traverses conducted at peak shopping time and after closing. All values were collected during a period of average trade wind conditions. Readings have been averaged and presented as zones of light, moderate or heavy particulate pollution on a typical evening in order to smooth the effect of any short-period high concentrations from unusually smoky vehicles or from dust particles carried by isolated wind gusts.

A number of interesting points emerge from these figures:

- 1) During the peak shopping period, zones of heavy pollution coincide in many instances with entrance and exit accesses where the acceleration and deceleration of stop-and-go traffic produce high exhaust emissions (Fig. 1A).

2) High particulate accumulations at the street level on the Sears end of the shopping complex during peak shopping hours persist into the period after the stores have closed (Figs.

1A and B). Apparently an air motion pattern, characterized by eddy formation at this end of the shopping complex, develops under normal trade wind conditions. The absence of this effect at the street level, Liberty House end of the center, an area cut off from the trade winds by ramp structures and neighboring buildings, substantiates this conclusion.

3) With the exception of the above mentioned phenomenon, suspended particulate concentrations measured in the sampling period after the stores had closed were substantially lower

FIG. 1, A-D.—Suspended particulate pollution index for the Ala Moana Shopping Center in Honolulu, November 1970.

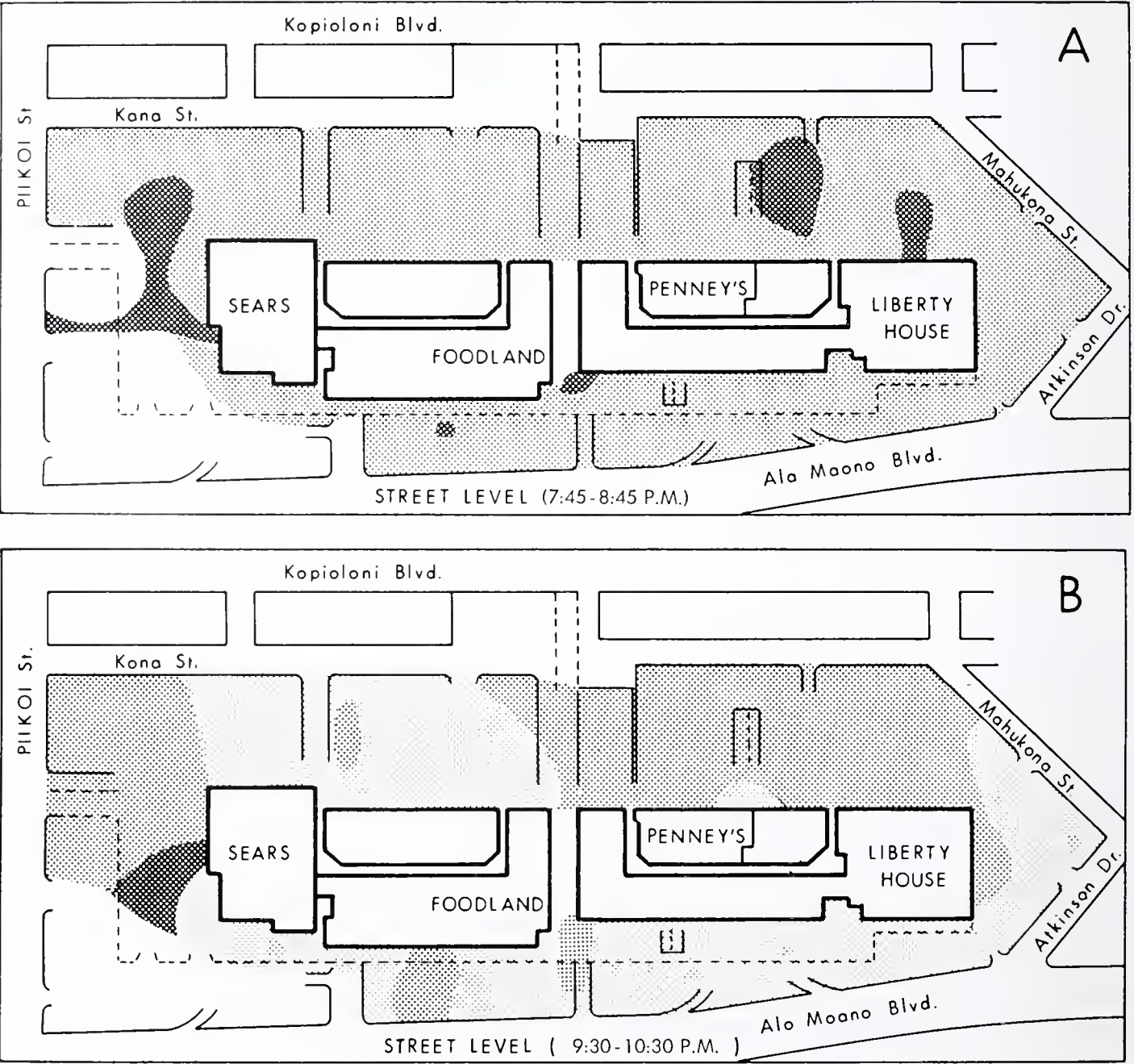
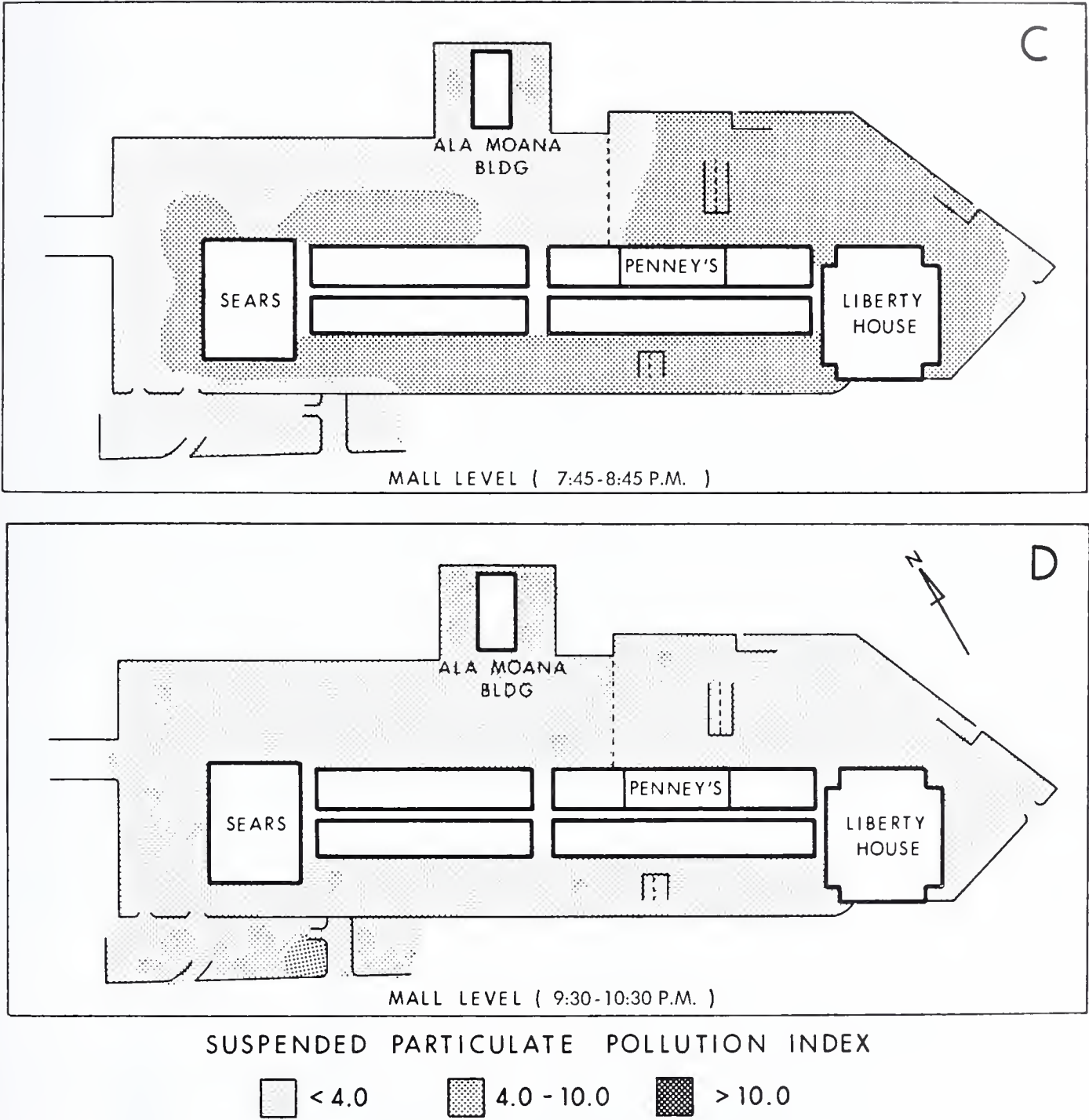


FIG. 1, A-D.—Suspended particulate pollution index for the Ala Moana Shopping Center in Honolulu, November 1970.



than those recorded during peak shopping hours (Figs. 1A and B). This indicates that it is the vehicular traffic that produces these small particles which, as will be shown later, constitute a significant health hazard.

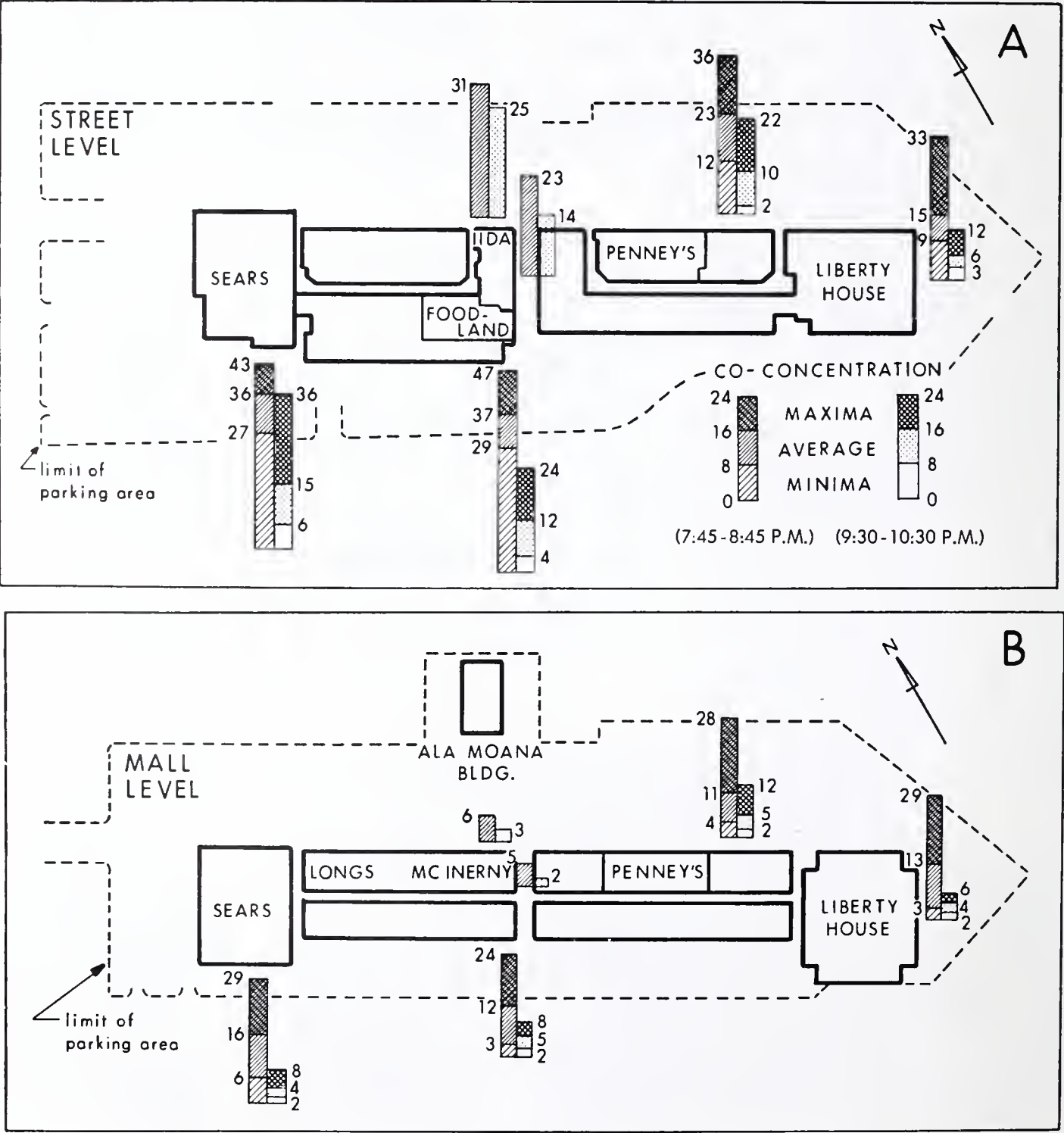
4) Street level concentrations of suspended particulates were markedly higher than concentrations at the mall level during the same sampling period (Figs. 1A and C, Figs. 1B and

D). Several spot wind-speed values were obtained, utilizing hand held hot-wire anemometers on both the street and mall levels. In general, wind speeds on the street level were three times lower than those on the mall level. Thus there can be little doubt to the somewhat obvious conclusion that ventilation, needed to disperse the pollution, is much weaker at street level than it is on the mall level.

Figures 2A and 2B summarize the results of the carbon monoxide sampling. The locations of the carbon monoxide values on the diagrams approximate the locations of the six representative sampling sites. Highest concentrations were found to occur on the street level with the maximum concentration of 47 ppm recorded on the south-western side during the evening peak shopping

period. Some moderately high values (29 ppm) were also measured on the mall level during this same period. Unfortunately it was not possible to conduct simultaneous traffic counts, but it can be safely assumed that these measured carbon monoxide concentrations can be closely related to the number of vehicles operating in the vicinity of the sampling areas.

FIG. 2, A-B.—Carbon monoxide concentrations (ppm) at street and mall levels in the Ala Moana Shopping Center in Honolulu, November 1970.



On the open and well-ventilated mall level, the carbon monoxide levels show a considerable reduction from peak shopping hour values to those recorded after closing (eg, at Sears: 29 and 8 ppm, respectively). Quite in contrast, the poorly-ventilated street level shows only a slight reduction in the measured values between these same times (eg, at Sears: 43 and 36 ppm, respectively). With such weak dispersion and dissipation conditions existing on the southwest and northeast sides of the shopping complex during trade wind conditions, it is quite probable that a potential health hazard may also exist in other locations of the Center under meteorological conditions not covered by this study.

The fact that the structure of this particular shopping center effectively traps atmospheric pollutants in certain places in such a way that they can accumulate to dangerous levels is further illustrated by the data in Table 1. In this table, concentrations of carbon monoxide obtained at certain concrete-covered locations on both the street and mall levels are compared to those values obtained at open air locations on the mall level.

TABLE 1.—Percent reduction of average carbon monoxide concentration as a function of sampling time and location at the Ala Moana Shopping Center in Honolulu.

LEVEL		PERCENT REDUCTION	
STREET (Covered)	MALL (Open to Sky)	7:45 - 8:45 P.M.	9:30 - 10:30 P.M.
Iida's	McInerny	81	88
Honolulu Bookstore	Carol & Mary	78	86
Foodland	Andrade's	68	58
Sears (south)	Sears (south)	56	73
Average		71	76

STREET (Covered)	MALL (Covered)		
	Liberty House	13	33
	Penney's	52	50
Average		32	41

Values are shown in terms of percent reduction of average carbon monoxide concentration as defined by the following ratio:

$$\frac{\text{CO covered} - \text{CO open}}{\text{CO covered}}$$

The data in the table show that during both the peak shopping and after-closing periods, the better-ventilated mall level has at least 70% less carbon monoxide pollution than the poorly ventilated street level. The percent reduction of average carbon monoxide concentration falls to only 32% in locations where the mall level itself is covered by a pollution-trapping concrete roof.

These results emphasize the importance of planning for protection of the public health. There is no longer any doubt that automobiles are a prolific source of atmospheric pollution. The designer of today's multiple level shopping complex must realize that by surrounding these buildings with multiple levels of covered parking he is creating a situation that is inherently conducive to the accumulation of potentially dangerous levels of automobile-generated pollutants. Future shopping center planners could avoid this situation by designing unifunctional, multi-level, above-ground, parking facilities to be located close to the shopping complex. Such facilities can be constructed so that each level is open to "through" ventilation, thus enhancing rapid dispersion of all harmful exhausts.

TOXICOLOGICAL EFFECTS OF AIR POLLUTION

Suspended Particulates

The potential toxic effects of aerosol inhalation depend upon the rate of deposition in the lungs, which in turn is dependent upon particle size, density and shape. Deposition of the particles in the respiratory system occurs by sedimentation, impaction, interception and diffusion.³ The fate of the inhaled particles of different sizes is briefly as follows:

- 1) Large particles ($\geq 10 \mu\text{m}$) are completely caught in the nasal passages, or at the back of the throat if the person is mouth-breathing. They do not travel below the upper bronchi.
- 2) Particles $5 \mu\text{m}$ in diameter penetrate the airways as far as the volume of inhaled air carries them.⁴ The elimination of particles from the respiratory tract has two main phases: the rapid phase during which particles initially deposited on the ciliary mucosa are removed within 10-20 hours, and the slow phase with a half period of 150-300 days during which half of those particles that have reached the nonciliated areas are removed.
- 3) Smaller particles ($< 5 \mu\text{m}$) reach the bronchioles and alveoli with maximum retention in the size range of $0.8\text{-}1.6 \mu\text{m}$ diameter. Some of these particles are carried upwards by ciliary action. The nephelometer with which our studies were conducted "sees" particles in the size range of $0.2\text{-}2.0 \mu\text{m}$ in diameter.
- 4) For particles below $0.2 \mu\text{m}$ the retention increases further as the effect of Brownian motion becomes dominant. In the alveoli the particles are engulfed by phagocytic cells,

which take them either through the walls of the lung tissue into the lymph and the blood capillaries, or to the bronchioles, from whence ciliary action may take them to the mouth to be excreted with the sputum. The dust-laden phagocytic cells are usually filtered out at the lymph nodes, and it is at these locations that fibrosis of the healthy lung tissue usually begins.⁵

It is now well known that the inhalation of large amounts of particulate matter can cause pulmonary diseases known in the different industries as miners' asthma, miners' phthisis, or grinders' rot.⁵ Pneumoconiosis, or literally a "lung containing dust," is the common term for all these diseases. The view first postulated by T. Legge and K. Goalby, that inhalation of toxic particles is more dangerous than ingesting them in food or drink, is now generally accepted.⁶ In general, the hazard of particulates to health depends on the nature of the pollutant, its concentration, the frequency and duration of high concentration occurrences, and the efficiency of an individual's respiratory tract to remove particles prior to deposition.

Cities in general and confined spaces in particular are known to be places with high concentrations of suspended particulates. The particulate content in the semi-ventilated Ala Moana Shopping Center originates predominantly from vehicular traffic, and, to some extent, from dust blown in from the surroundings. Of particular concern to health are lead particles, the most common compounds of which are the various oxides PbO, Pb₂O₃, Pb₃O₄ and the mixed salts such as PbClBr and PbNH₂Cl, which are all produced by burning the gasoline additives tetraethyl lead (TEL) and tetramethyl lead (TML).⁷ Lead is known to adversely affect the central nervous system.

Seemingly inert particulates appear to act as carriers for carcinogens which produce malignant neoplasms in the lung. According to Saffiotti et al., the increased malignant action of the carcinogen is caused by its impaction on small inert particles which carry it unabsorbed through bronchioles and alveoli into the lung parenchyma.⁸ If carcinogens such as benzo(a)pyrene were not absorbed on a particle, they would presumably be removed rapidly from the lungs. In a recent paper, Coffin concluded that carcinogenic polycyclic hydrocarbons coupled with seemingly inert particles have proven the best means of producing malignant tumors in the lungs of experimental animals.⁹ Thus, it appears that aerosols increase the

carcinogenic effects by enhancing the penetration capability of the carcinogenic substances, and by weakening the mechanisms for eliminating unmetabolized carcinogens.

The human defense mechanism against these small deleterious particles is rather poor. The nose is actually quite a helpless device in filtering out these small particles.¹⁰ Thus, protection against these hazardous particles can to some extent be achieved by good ventilation. On the lower decks of the shopping center and in leeward niches, those people whose occupation necessitates longer stays should wear some kind of a protective device. The cheapest and most convenient devices on the market are respirators with particle filters which cover both the nose and the mouth.

Carbon Monoxide

Carbon monoxide poisoning is characterized by headache, nausea, dizziness, irritability and disturbed sleep followed by fatigue. Persons with anemia and cardiovascular insufficiency are especially affected.

The inhalation of CO leads to increased levels of carboxyhemoglobin (COHb) in the blood, the physiological response appearing as tissue anoxia and blood hypoxaemia. The mechanism of COHb formation is as follows: CO enters the lung's alveoli, diffuses through the alveolar membranes into the blood stream, penetrates the red blood cells, and finally combines in a ligand-type bond with the reduced iron of the hemoglobin. Since the dissociation rate of COHb is much slower than its rate of formation, the affinity of hemoglobin to CO is about 240 times greater than that to oxygen. Association and dissociation rates, which result at equilibrium, can be calculated from the following simplified relationship between the level of COHb and the concentration of CO with inhaled air:¹¹

$$\% \text{ COHb} = 240 \frac{\text{pCO atmospheric}}{\text{pO}_2 \text{ arterial}} \% \text{ O}_2\text{Hb}$$

The curve denoted as infinite time in Figure 3 is based on this equation. The figure shows the percent COHb in the blood versus atmospheric CO for shorter time periods, and additionally lists the health symptoms at different levels of COHb. For example, objective tests have shown impairment of vision at COHb levels over short periods as low as 5%. Although the physiological response to CO which is manifested in an increased COHb level in the blood, is well under-

stood, the information regarding actual adverse effects is still inconclusive. This is because the symptomatic response is often disguised by such interfering factors as tobacco smoking or the individual's particular state of health, as evidenced by his blood chemistry.

Large numbers of occupational studies have been conducted regarding the exposure of thousands of people to different dosages of CO. These studies were designed to find answers about 1) the concentration of CO in the ambient air and the average duration of CO exposure; 2) the levels of COHb in the blood of the exposed population; 3) the contributing effects of tobacco smoking; and 4) the amount of hemoglobin and the number of the erythrocytes.^{12, 13, 14, 15} In a recent study, Goldsmith, a leading authority on CO poisoning, described the effects of CO on the central nervous system.¹⁶ Since the CNS consumes 20% of the available oxygen in the blood, it exhibits the highest sensitivity to reduced arterial oxygen pressures. Functions which depend upon an external stimulus, such as vision or judgment, seem to be impaired at COHb levels as low as 2%. At 5% COHb the transport of oxygen is impaired, and at 10% COHb symptoms of this impairment can be recognized.

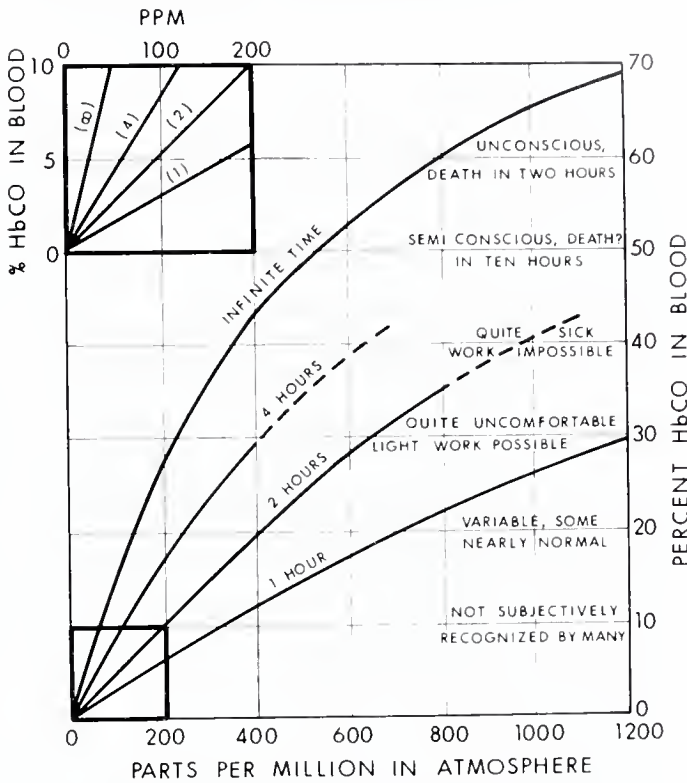
Some of the above studies also seem to indicate that the body burden of COHb from either the ambient air or tobacco smoking is acquired accumulatively. Also, long-term exposure to moderate CO concentrations may not show any of the expected symptoms, but certainly increases the COHb-levels. The phenomenon of CO acclimatization as reviewed by Otis, is widely disputed in the literature.¹⁷ The experiments of Kallick and Gorbатов as quoted by Otis¹⁷ seem to indicate that changes in blood composition or changes in the mechanism of diffusion across alveolar membranes might permit adaptation to long exposures of low to moderate CO concentrations.

The potential effects of CO concentrations recorded at the Ala Moana Shopping Center were related to the following groups of people: 1) shoppers; 2) employed personnel; 3) medically vulnerable people; and 4) smokers.

Shoppers

Considering the highest recorded CO concentration of 47 ppm (see Fig. 2A) and an exposure time of 2 hours, Fig. 3 suggests that a COHb level of 2.5% is possible. This figure is on the high side, because the average shopper spends his time in-

FIG. 3.—Comparison of atmospheric carbon monoxide with the percent carboxyhemoglobin in blood.¹¹



side and outside the stores. However, there are quite a number of people who hang out for hours at the street level rest areas, who might be subjected to the above dosages. At any rate, the possible 2.5% COHb-level is above California's air quality standard for CO which allows COHb-levels of only 2%.

Employed Personnel

This category includes clerks, cashiers, short-order cooks, mechanics, and sales personnel in general, as well as security guards. Many automobiles still have CO emissions in excess of 0.6% (6000 ppm). Thus, even at dilution factors in excess of 100, CO concentrations of between 30-50 ppm should be expected on the sidewalks, at the store entrances and at the many open street-level restaurants. Although these high concentrations might be of short duration, they certainly recur frequently. This frequent exposure to waves of high CO concentration needs further clinical investigation.

Since many shops operate with their doors open, some of the following factors may influence the fraction of polluted air that might enter the shops: orientation of the doors towards the wind direction, distance of the stores from traffic, and the existence of forced air ventilation. Even well-

ventilated stores may just draw in polluted air from the outside and distribute it equally over the store.

Medically Vulnerable People

On the basis of physiological evidence, the groups of people expected to be most susceptible to adverse effects of CO would include persons with severe anemia, impairment of circulation to vital organs, and diseases that result in increased oxygen demands. It has been estimated that the threshold for the interference of oxygen transport in sensitive and sick people is as low as one-third that of healthy persons.¹⁸ Of particular concern is the effect of CO on the health of children. Since they have higher metabolic and respiratory rates, one might imply a greater adverse effect of CO on them. It is our contention that the street level play area which is in proximity to the highest pollution concentrations that we recorded at the shopping center, should be moved to better ventilated upper deck areas.

Smokers

It has been shown that cigarette smokers have COHb levels which in general range from 3 to 20%. The magnitude of the COHb levels depends on the number of cigarettes smoked per time period, the style of smoking, and the degree of physical activity. If the CO absorption and excretion through lung tissue is an equilibrium process, one must then conclude that smokers who subject themselves to the moderately polluted air of the Ala Moana Shopping Center will preserve their body burden of COHb longer than if they breathed clean air. The half-life of COHb is about 5 hours.¹⁹

SYNERGISTIC EFFECTS

A discussion of the adverse health effects of CO would be incomplete without a brief look at the synergistic potential of CO and nitrogen oxides (NO_x). From the magnitudes of our recorded CO levels and those recorded by Ishikawa²⁰ for nitrogen oxides (0.02-0.44 ppm), adverse synergistic cardiovascular effects could occur leading to carboxyhemoglobin anoxia and methemoglobinemia. Studies have shown that patients who were subjected to the inhalation of NO_x had greater levels of methemoglobin, the oxidized form of hemoglobin. Since methemoglobin is not capable of fixing oxygen or CO, the synergistic effect of CO and NO_x would be a more reduced arterial oxygen tension than if the inspired air contained only CO.^{21, 22, 23}

An additional adverse effect of NO_x and CO is the interference with the pulmonary cleansing activity of the cilia and mucous membrane. This causes a reduced absorption for mucous soluble pollutants and especially suspended particulates in the 1-5 μ m range. Increased susceptibility to bacterial infection is the probable result.^{24, 25}

MORBIDITY AND MORTALITY

Through laboratory experiments involving mice, rabbits, dogs, etc., the adverse effects of automobile exhausts present in breathing air at concentrations common in our cities have been demonstrated. The results usually are increased morbidity, associated with pathological changes in respiratory functions, causing chronic diseases in larger animals or direct mortality in smaller animals. Increased morbidity in test animals is usually verified by pneumococcus or streptococcus bacteria.^{26, 27, 28}

Several studies have related urban air pollution levels with incidence and prevalence of disease.^{29, 30} The results from these investigations, which included 61,000 person-weeks, can be summarized as follows: 1) the prevalence of headache and eye irritation correlates positively with CO; 2) incidence and prevalence of the common cold correlate highly with hydrocarbons; 3) sore throats were found to be highly related to suspended particulates; and 4) the incidence and prevalence of cough correlated highly with all four air pollutants.

It is well-known that the occurrence of respiratory and other infectious diseases in Hawaii is relatively high.³¹

RECOMMENDATIONS

Based on the overall conclusion that heavy peak shopping hour traffic can produce potentially dangerous concentrations of air pollutants at certain locations on the poorly-ventilated street level of the Ala Moana Shopping Center, the following specific recommendations are made:

- 1) The children's playground, currently located on the street level only about 20 feet from heavy traffic, should either be moved to a suitable location on the well-ventilated mall level or closed. The present location of this playground constitutes a most blatant example of planning with total disregard for the ill effects that car pollution can have on the health of a particularly susceptible segment of the population patronizing the Center.
- 2) Street level shops now ventilated by leaving

their doors open, or by utilizing small individual air conditioning units located over doorways should install central forced-ventilation air conditioning system, which can bring in clean air from rooftop levels. Again, better environmental health planning on the part of the shopping center designers could have eliminated the need for this recommendation.

- 3) The street level traffic flow pattern should be altered so that heaviest traffic is diverted away from the many sidewalk benches and stone entrances. By posting and enforcing signs prohibiting engine idling, the pollution concentrations in these areas could be decreased somewhat.
- 4) Shopping center employees who are exposed for long periods of time to the relatively high pollution concentrations measured at many street level locations should be provided with respirators. These respirators are neither inconvenient nor expensive when considered in terms of the effects that long-term exposure to these potentially hazardous exhaust effluents might have on their general health and well-being.
- 5) Persons particularly susceptible to the ill-effects of air pollution, eg, people with anemia, cardiovascular insufficiency and respiratory ailments, should avoid the street level areas,

or at least schedule their shopping trips there on days when the auto traffic is lightest, ie, Tuesdays, Wednesdays and Thursdays, and between 10 a.m.-12 m. and 1:30-6 p.m.

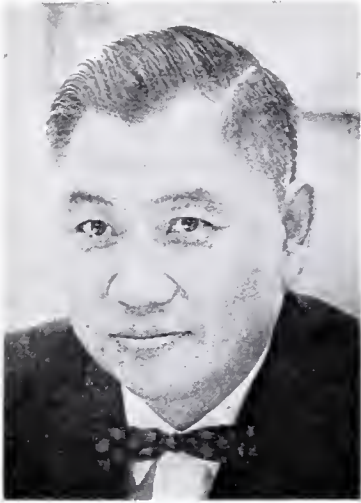
- 6) Since the pollutant concentrations measured at the street level of the Ala Moana Center are among the highest measured on all of Oahu, and since such a large segment of the urban population is periodically subjected to these concentrations, it is recommended that at least one, preferably two, monitoring units and alarm systems be set up here to determine the concentrations of suspended particulates, carbon monoxide, nitrogen dioxide, and hydrocarbons.
- 7) Designers of future shopping centers could prevent the accumulation of hazardous pollutant concentrations by designing unifunctional, multi-level and above-ground parking facilities which are close to a shopping center and open to through ventilation to disperse the pollutants.

ACKNOWLEDGMENTS

This work was sponsored by the Atmospheric Sciences Section, National Science Foundation, N.S.F. Grant GA-23660. The authors also wish to express their thanks to a large number of University of Hawaii students for their help in collecting the data.

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The President's Page

In the short time it has been my privilege to serve as your President, I have come to view with awe the potentialities of our Association. How much more effective our Association could be, if our committees were able to function full-time rather than "in addition to your practice"!!!

In the past few months, our HMA members have shown that there is no lack of interest in our several ongoing activities. They have been willing to participate and have demonstrated that our Association can be effectively involved in more than one project at a time. Since resources in time are limited, priorities must be determined. In areas which generally affect health and medicine, community programs must not be limited to one organization or institution.

The rapid developments in changing methods of health care delivery, in broad-based cancer research, in allied medical manpower training programs must have active input, and representation from the practicing medical community in the formative stages, if the programs are to be practical or based on sound medical principles.

I would like to see the HMA become a force through which fragmented efforts by various bodies working in these areas could be brought together and coordinated effectively into approaches that are medically sound.

To succeed, the Association must continue to keep itself informed with committees and chairmen becoming experts in their areas. It is equally imperative that physicians involved on various community and university committees keep the HMA informed of any developments.

Robert Y. H. Chin



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help—for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

Minors, ObGyn Practice and the Law

With the past, current and probably endless debate on women, abortion, and medical care for minors, we present herewith data gathered by the Hawaii Section of the American College of Obstetrics and Gynecology. Practices, present and projected, of their membership, were polled in a mail survey in November, 1971. Over seventy per cent of the more than fifty Fellows and Junior Fellows in the State responded.

Concerning pregnancy, contraception, birth control pills, venereal disease and sexual counseling, between 55 and 80 per cent of respondents are now serving minors, but 90 to 100 per cent say they would do so if permitted by law.

Only 15 per cent are currently performing abortions on minors, but 75 per cent would be willing to do so if the law allowed. Seven members stated they would not do abortions on minors without parental consent, even if the law were changed. Of this group, four said they do not do abortions under any circumstances.

IUDs are now provided to minors, that is girls under 20 years of age, by 30 per cent of respondents, but 90 per cent would offer this service if enabled. Of the 2,136 new patients seeking contraception in a typical month, 20 per cent were minors. Birth control pills accounted for over half the total prescriptions—1,126.

Of the 481 new obstetrical patients in a typical month, 15 percent or 72 were under 20 years. Of 88 with VD, 35 were minors. Asking for abortion were 73 minors in the first trimester and 20 in the second trimester.

Of those Fellows responding as to their reservations about serving minors without parental con-

sent, 90 percent named “possible liability” as their primary concern. To all those stalwarts called upon to make decisions in this area, we on the sidelines extend our deepest condolences on several levels.

The tables supplied by the ACOG-Hawaii Section follow:

DORIS R. JASINSKI, M.D., M.P.H.

TABLE 1.

TYPE OF CARE	PERCENTAGE CURRENTLY SERVING MINORS	PERCENTAGE WILLING TO SERVE MINORS IF LAW CHANGED
Pregnancy	55%	90%
Contraception	75%	100%
Birth Control Pills	80%	100%
IUD	30%	90%
Venereal Disease	80%	90%
Abortion	15%	75%
Sexual Counseling	80%	100%

TABLE 2.—Estimates of a typical month's patient visits (29 Fellows responded).

TYPE OF VISIT	TOTAL NUMBER OF PATIENTS	PERCENTAGE MINORS
New patients seeking contraception	2,136	30%
A. Birth control pills	1,126	30%
B. IUD	289	10%
C. Diaphragm	60	5%
D. Foam	325	20%
E. Sterilization	220	0%
F. Other methods	16	5%
New Obstetrical Patients	481	15%
Venereal Disease	88	40%
Sexual Counseling	245	25%
Abortion		
A. 1st Trimester	292	25%
B. 2nd Trimester	50	40%

Summary of Hawaii Section, District VIII ACOG Survey of Family Planning Services, November, 1971.

Please Report Transfusion Hepatitis!

Screening of blood donors for hepatitis-associated antigen has significantly decreased the risk of post-transfusion hepatitis. When it does occur, weeks to months later, the patient is often treated

at home or is in the hospital for only a short time; the blood bank rarely hears of the case.

The Blood Bank of Hawaii makes a plea to all physicians treating suspected post-transfusion

hepatitis to report it to the Blood Bank. Our extensive records, tracing every unit of blood from its source through its entire use, perhaps involving 3 or 4 components, are valueless without your assistance in initially reporting the case to us. Detailed records allow us to exclude suspected donors (even

though the test for hepatitis-associated antigen is negative) based on information from the clinician which implicates them. With your help we hope to further decrease the incidence of post-transfusion-hepatitis.

JULIA FROHLICH, M.D.

Air Pollution

Messrs. Bach and Lennon of the University of Hawaii Air Pollution Task Force have, elsewhere in this issue, delineated a fact some of us have been aware of for several years: there is serious air pollution on the street level at Ala Moana Shopping Center.

This pollution has been particularly noticeable and noxious on hot days—late in the day—on the leeward side between Scars and Keikiland. In truth, one looks for alternatives to experiencing

this pollution—even so far as shopping at other Centers!

To the several cogent suggestions the authors make for improving this “exhausting” situation, let us offer one other: install large fans and conduits to blow the noxious effluvium away from the street level and to suck cleaner air in.

We will all be grateful if suggestions herein lead to some improvements!

DORIS R. JASINSKI, M.D., M.P.H.

Certified Medical Representatives

Your drug house representative (detail man), if he works for CIBA, Dorsey, Syntex, Warner-Chilcott, A. H. Robins, Ortho, Dorsey, or Knoll, can take a correspondence course over a period of two to five years leading to his designation as a Certified Medical Representative. Only representatives of these firms, which are the only ones that now support the program of the Certified Medical Representatives Institute, are eligible.

The schooling comprises credits in anatomy, physiology, pharmacology, medical terminology, and government regulations, plus a broad range of elective subjects.

Over 450 men have completed the required course so far, and the program is said to be growing. The failure rate is between 15 and 20%, which speaks well for the seriousness of intention

behind the program, and the total dropout rate is only 3%, a creditable showing.

Practicing physicians can learn a lot from conscientious, well-informed pharmaceutical representatives; they do well to give them a courteous hearing when they call. The chance that this will happen cannot help being improved by upgrading even further the educational level of this group of dedicated salesmen. This program seems likely to accomplish that.

If you see “C.M.R.” after your pharmaceutical representative’s name, be aware that it represents a large investment of effort on his part and stands for an unusually high level of professional excellence as well.

Information about the Institute may be obtained from Fred C. Goldthorpe, Ph.D., at 410 Elm Avenue S.W., Roanoke, Va. 24016.

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

... **Legislative Committee** meeting weekly now, with the legislature in session. Primary concern is malpractice. Two approaches: Dr. Pavel proposes an arbitration board, composed of a judge, lawyers, and doctors. SB 1559 proposes prohibiting contingency fees in medical malpractice—like the British and Canadian systems. But do you really think the lawyers, who control the legislature, will go along? No other state has been able to do that. Only one state, Alaska, has even eliminated *res ipsa loquitur*, which is the real troublemaker. Why not shoot for following Alaska's lead? But we'll have little luck influencing the legislature until we get a better lobbying setup. We need an effective public relations program, an effective lobbyist, and a one-to-one (M.D. to legislator) system.

... **Quackery** concerned about chiropractic ads. Logical thing (seems to me) is to file suit under deceptive practice law. Typical HMA committee—lots of discussion. No decision or action.

... **TV-Radio** working hard on new TV program. No longer on ETV, but picked up by KGMB. Costs more (as you'll learn in May, in the new budget) but worth it. Title now is "HMA Hotline." I don't like the title—who knows what HMA means?

... **Joint Public Relations** has appointed members to work closely with each news outlet. Should help out relations with the press. Still awaiting approval by the Council is the new Code of Cooperation. Come on, fellows, let us go ahead with this. Each month more of delay worsens our relations with the press. Action, please.

... **Health Manpower** bogged down in Physician's Assistant proposals. Last idea is against separate licensing, but to have each doctor wanting to use a P.A. apply for same, giving proposed

duties to be delegated, with certification on an individual basis, and recertification every two years. A lot of work for the Board, but likely needed at present stage of things.

... **Environmental Health** still pussyfooting around, with no clearcut goals or decisions, and apparently will have none in time to influence this legislative session. But that is HMA's fault, basically. What are our goals?

... **Drug Abuse** has received a report about one physician in the state who is breaking the medical code of ethics, but narcotics people are unable to get evidence. Voted to write a letter to Dr. Chinn saying that "something should be done about this doctor." Aw, come on. Is that Herb's job?—to gather evidence the cops can't, or to take action based on accusation, with no evidence, when your committee can't make a specific recommendation? Get off Herb's back. He's got enough problems already.

... **Research and Planning** and **Cancer** studying proposal of National Cancer Institute to set up a Cancer Center. Supposed to be for research only—no patient treatment. If so, it is probably a good idea.

... **Communicable Disease** pushing VD program. Are you doing GC smears on all your pelvics? (I'm not, but plan to start.) We are told to expect a yield of 2% unsuspected positives. If so, it's worth the effort. Did you know you can get free culture media, etc., from the Health Dept.?

... **Water Safety** asks how do we keep people out of the water in Waimea Bay, our greatest killer of tourists. Surely you have some suggestions, men, after studying it all these years. How about barbed wire????

Aloha,

JOHN BROWN, M.D.

Hawaii Academy of Family Physicians

..... EMCRO

The Experimental Medical Care Review Organization (EMCRO) is a federally funded project of the Hawaii Medical Association. It purports to evaluate the quality of medical care dispensed by physicians in their offices.

The criteria for optimum care have already been delineated by panels of your peers interested enough in continuing medical education to put in a lot of their valuable time. These criteria are not fixed. EMCRO sessions in process are trying to involve more and more physicians in this mechanism—which is actually peer review except that it is pre-care rather than post-care review—with the intent of up-dating these criteria for management of specific disease entities, and of expanding coverage to include diagnoses other than the original 13 evaluated in the Beverly Payne study of 1969-1971.

The part of EMCRO that is actually peer review is the feedback: Hopefully, physicians who participate will learn from their colleagues or be reminded of the essence of optimum care of their own private patients. EMCRO will then, later, try to determine whether such efforts are worthwhile by conducting another survey or study.

HMA is receiving recognition throughout the nation for being the first medical society to initiate this form of peer review. The emphasis is on the continuing education of practicing physicians, which is what the profession appreciates more than the retroactive audit and utilization review that has always had a connotation of being somewhat punitive.

Any two physicians meeting anywhere and “talking shop” constitutes peer review, of course. And so do medical staff meetings, in general, in departments, and in committees in hospitals. These are or can be medically instructional if the participating physicians listen and learn. However, there is doubt as to whether such opportunities are equally available to physicians primarily concerned with office practice. Many of these do not discernibly attend

scientific medical meetings at professional society levels, much less the hospital gatherings, though probably they do read the wealth of medical journals piling up on their desks. EMCRO is a project designed not only to look into this aspect of medical practice, but also to be educational in so doing.

In-hospital practice of medicine has had a long history of peer review. The basic premise is an adequate patient work-up and treatment as manifested in the hospital chart. The reports of audit committees of one sort or another are meant to confirm or to expose the adequacy or the inadequacy respectively. Without “the record,” a proper evaluation cannot be done—unless a lot of additional time and effort is expended in calling in the attending physician to a “hearing.”

Out-of-hospital medical care has no such history of peer review as a built-in mechanism. EMCRO is “experimental” in the sense of trying to incorporate such a system—of standards, criteria, critical review of methods, etc.—into office practices. EMCRO has already discovered that good care provided by top quality physicians is often unrecorded. Current review mechanisms make this appear to be “bad” medicine—often quite falsely.

Too much time and attention given to the recording thereof may well divert too much effort away from actual care of the patient. Too much emphasis on recorded methodology may lead to conclusions not borne out by a study of the “outcomes,” i.e., the end results of treatment.¹

EMCRO, under the able direction of Alex Anderson, MD, and Max Botticelli, MD, of RMP, and under the paternalistic aegis of HMA’s Continuing Education Committee, is a serious attempt to find appropriate answers for the profession. If “providing our patients with the best possible care” is our goal, then we need to participate in EMCRO and support it to the hilt.

J. I. FREDERICK REPPUN, M.D.

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Bovine Psychotherapy

One of the most staid and respectable pillars of the financial world is the *Financial Times* of London, well known as the best business newspaper in the world. Surprisingly, in the March 10, 1972 edition, carefully concealed amidst news of stocks and bonds, was to be found a small column entitled "Bullshit as Psychotherapy" which described in some detail the recent tribulations of Ms. Germaine Greer of Women's Lib fame: —

"The news that Miss Germaine Greer, author of *The Female Eunuch*, is to be charged in court today in Auckland, New Zealand on charges of using the word 'bullshit' in a public lecture, should bring pleasure to the hearts of the managers of the Pneumatic Rubber Company of Wandsworth, London, which at the invitation of an American company has just produced a pre-inked rubber stamp with 'bullshit' inscribed upon it—probably as the company remarks, 'the first of its kind in the U.K.'

"The Pneumatic Rubber Stamp Company goes on to say that 'it was felt that while solving the problem of classifying certain types of information, the stamp would also offer clear psychotherapeutic benefits to the user in having the satisfaction of ascribing this particular item to the offending information.'"

While "bullshit" has not yet become acknowledged as a generic management term acceptable on this side of the Atlantic, the Pneumatic Rubber Stamp Company of Wandsworth is forecasting that it will soon catch on.

With help from Germaine Greer it cannot fail!

Incidentally, during the subsequent trial Ms. Greer testified that she used this earthy barnyard term because "there is no other word in our dialect which depicts so effectively a specious argument."

We are inclined to agree with her opinion and apparently so did the judge, who ordered the charge dismissed.

Amphetamine Abuse

Certain patients continually plague their physician to supply them with "diet pills to lose weight" and usually become quite upset if their request is

denied. A study of their medical records usually reveals that they have been taking amphetamine-containing appetite suppressants for many months, sometimes years, with absolutely no change in their body weight. Indeed in some instances they have even gained weight while taking the weight-reducing pills.

Why then do they continually request prescription refills when obviously the medication is not making them lose weight? Because they have become amphetamine-dependent.

A comprehensive article on the Problems of Amphetamine Abuse by Grimspeen and Hedblom (*Drug Therapy*, January 1972) makes for some disturbing reading. They state: —

"The amphetamines have finally begun to receive appropriate recognition as extremely toxic psychoactive drugs which are capable of causing violent antisocial and criminal behavior, severe psychologic and possibly physiologic damage, and strong dependence . . . nor does anyone know exactly how much amphetamine is legally produced. However, the existing evidence does indicate that amphetamine use has significantly increased since 1966 when a conservatively estimated ten million Americans consumed a reported 81,400 pounds (nearly 8 billion tablets), an amount sufficient to supply every man, woman and child in the country with 35 standard 5-mg doses."

Because of the strength and persistence of this amphetamine-induced drug craving, and because many persons who eventually abuse these drugs began their use (whether obtaining them by prescription in the course of medical treatment, or by some illegal means) as a result of their feelings of depression, relapse to further amphetamine use often occurs during withdrawal when the original depression is inevitably compounded by the post-drug-use let down. . . . Drug therapy during the long term treatment of acute and chronic amphetamine abusers is generally, at best, illogical. Individual physicians, not only psychiatrists, but specialists in all areas, as well as general practitioners, who have perhaps overprescribed amphetamines in the past, should be

continued page 146

The Riddle of Cruelty

By G. Rothman, M.D., 210 pp., \$7.50, Philosophical Library, 1971.

MAN'S UNLIMITED ABILITY to commit mayhem on himself and others has long been a puzzle. Dr. Rothman, in attempting to answer this riddle, responds with psychoanalytic formulations. Sadism, masochism, and sexual deviations are largely attributed to early deprivation, separation, unusual childhood punishments, or sexual abuse, with subsequent psychological maldevelopment of ego defenses. The author is careful to illustrate his thesis with case histories so that in any particular case there is a wealth of material which one might consider etiologic in the development of masochistic and sadistic character traits. In addition to cases with which the author is personally familiar, there is a plethora of historical anecdotes of old horrors and accounts of particularly cruel events culled from the literature. Except for an early reference to the development of a faulty "aggressive" drive, cruelty is seen to be largely the result of faulty nurturing. There is an interesting chapter on cruelty perpetrated by members of the medical profession; surgeons, dentists, and psychiatrists all come in for their lumps. The book should be of interest to any medical person.

KWONG YEN LUM, M.D.

★Lasers in Medicine

By Leon Goldman, M.D., and R. James Rockwell, Jr., 385 pp., Gordon and Breach, Science Publishers, Inc., 1971.

"A COMPREHENSIVE survey of this fascinating new innovation in medicine."

WINFRED Y. LEE, M.D.

Understanding Laboratory Medicine

By Camillo V. Bologna, M.D., 259 pp., \$9.80, Mosby, 1971.

"A GOOD reference text for the house officer and anyone interested in the fundamentals of laboratory medicine."

WINFRED Y. LEE, M.D.

★A Radiographic Standard of Reference for the Growing Hand and Wrist

Assembled by S. Idell Pyle, Ph.D., Alice M. Waterhouse, M.D., and William Walter Greulich, Ph.D., 121 pp., Year Book Medical Publishers, Inc., 1971.

"AN EXCELLENT reference standard for evaluating bone age, updated and incorporating the aid of the National Center of Health Statistics. An outstanding text book!"

WINFRED Y. LEE, M.D.

★Introduction to Hematology

By William M. Dougherty, B.S., 253 pp., \$10.50, Mosby, 1971.

"AN EXCELLENT text for the house staff officer or the physician who wants a current introductory review of hematology."

WINFRED Y. LEE, M.D.

Autogenic Therapy, Vol. 5: Dynamics of Autogenic Neutralization

Edited by Wolfgang Luthe, M.D., 344 pp., \$17.50, Grune & Stratton, 1970.

THIS IS volume 5 in a series developed to give a complete view of a systematic approach to therapy. This volume deals with the dynamics of autogenic action, and the development of thematic programming during therapy.

KWONG YEN LUM, M.D.

★Current Diagnosis and Treatment

By M. A. Krupp and M. J. Chatton, 962 pp., \$11.00, Lange Medical Publications, Los Altos, California, 1972.

THIRTY-SIX CONTRIBUTORS, 24 from UC Medical Center in San Francisco and 7 from Stanford (though both editors are on the Stanford faculty!), have prepared this 11th annual edition, and it's a damn fine job!

This 4-cm thick fabricoid-bound volume is intended as a desk reference for the practicing physician, not a textbook of medicine. Its usefulness may be gauged by the fact that it is published also in Italian, Spanish, Romanian, and Serbo-Croatian. Literature references as recent as 1970 and even 1971 are plentiful but selective.

Sections by Rees B. Rees, Jr., on skin diseases, by Ernest Jawetz on antibiotics, and by Sydney Salmon on cancer chemotherapy, are outstanding. Jawetz's tabulations of antibiotic incompatibilities in vitro and in vivo, doses in renal failure, and first and alternative choices in specific infections, are invaluable and up to the minute. The division of most of the book on the basis of anatomical systems makes for ready reference.

In a table of abbreviations, nm and ng are missing, though obsolete A is still there; roentgen is incorrectly given as "r" instead of "R"; and the abbreviation of diphenylthiourea is misprinted as DDT instead of DPT, perhaps because a rival definition, diphtheria-pertussis-tetanus, immediately follows.

Concise, authoritative, inclusive, convenient, up-to-date, and inexpensive, this volume should be on the desk of every generalist and internist and within reach of every specialist, for quick reference to the best current practice in every medical field.

HARRY L. ARNOLD, JR., M.D.

★ means highly recommended.

Tom Thorson's Corner

A rabbi and a priest lived across the street. . . . The priest came home with a new car and started to sprinkle it with holy water. . . . The rabbi was curious and asked, "What are you doing?" "Since the parish bought the car, I'm blessing and dedicating it to the works of God." Not to be outdone, the rabbi also bought a new car, a sporty model. Upon reaching home, he went down to his workshop, came back with his hack saw and soon busied himself sawing 4 inches off the protruding exhaust pipe. . . .

Two flies were buzzing around and finally landed on the handle of a knife lying across a plate of cold cuts. . . . They gorged themselves so that when they tried to fly, they promptly dropped to the floor. . . . (A modern day Aesop's tale: "Don't fly off the handle when you're full of baloney. . . .")

HCMS Meeting of 2-1-72

When new member **Melvyn Kauneshiro** reminded us that there was a County Society meeting that night, we had to admit that we hadn't been too religious about our attendance. To our delight, we discovered that the meetings were quite pleasant minus the traditional verbal slugfests. . . . As we slipped in, **Chew Mung Lum**, at his eloquent best, was making an impassioned plea for "solo practitioners to think about and participate in EMCRO." He described EMCRO as an "idea of self assessment and self evaluation." Chew Mung warned: "In the immortal words of Oliver Wendell Holmes, 'The greatest assurance for triumph of evil is for good men to remain idle.'"

HCMS prexy **Wini Lee** introduced **Donovan Ward**, past president of AMA, etc, etc as "a really great guy." Donovan spoke on the "Value of AMA," but first, proud of his newly acquired Hawaiian vocabulary had to say, "I bring you aloha from other AMA members. . . . I say to you mahalo nui loa. . . ." We learned that historically, 250 physicians first met in 1847 and organized the AMA with the express purpose of "promoting the art and science of medicine and the betterment of public health. . . ." A John Hamilton, editor of the Journal in 1896, an LLD and MD, wrote an editorial, "The Medical Student" in which he described the medical student as standing 5'7" and trained as a handy man for home life, ie, in planting, plumbing, carpentry, etc. . . . Donovan complained that nowhere was there any reference to intelligence. "I was especially disconcerted about the part about being 5'7" . . ." (a reference to his own short stature). Donovan pointed out that Hippocrates made no mention of threats or undesirable punishments, but today's rules say: "Thou shalt give up solo practice for group practice. . . . Thou shalt abandon fee for service. . . . Thou shalt choose those medicines only from the National Formulary . . . and lastly thou shalt keep thy mouth shut. . . ." He lashed at the distortion of the physician image perpetrated by legislators, publishers, intellectuals, and reporters. He was particularly distressed that "some of the most enthusiastic proponents of this image are our own physicians." He admitted there was "internal strife from petty disagreement . . . but we are all physicians. . . . If we are to maintain integrity and freedom to practice, we must remain together. . . . What-

ever our specialty, whatever our interests, we are all physicians. . . . Physicians have to be organized for a strong voice. . . . Go ahead and disagree with the AMA, but don't quit. . . . Bless it and cuss it, but keep it within the family. . . .

An unusual aspect of the meeting was the ritual called "Honor Our Colleagues" (ie, our elder statesmen who have devoted more than 4 decades to their medical society). From the long list of names called, however, only 10 were present, viz, **Douglas Bell, Marie and Robert Faus, Don Marshall, Joseph Hathaway, Fred Lam, Sr., Joseph Lam, Robert Millard, Kazuo Miyamoto, Joseph Strode, and Clinton Culpepper**, and they received certificates of recognition from Donovan Ward.

Wini reported that **Mr. Robert Hasegawa**, Director of the Labor Dept., would be the next meeting's speaker. . . . He related how a physician annoyed with the workman's comp schedule wrote on the form, "Shove it!" and even signed his name. Wini warned, "This may represent our deep down convictions, but we must remember we are physicians," and that anyone being disrespectful toward Mr. Hasegawa at the next meeting will be personally escorted out of the meeting. . . .

Quotable Quotes

Murphy's Law: "All bleeding ultimately stops." (*Franz Bauer—USC Symposium for Critical Care at LA Hilton*).

"The longer the symptoms before seeking a physician's help, the better the prognosis; conversely, the shorter the symptoms, the poorer the prognosis." (*V. K. Vaitkevicius, Director of Oncology, Wayne State and Tutor Oncologist in Feb.*).

"The risk of surgical complications is relative to heart disease. . . . The treadmill test is the most definitive prognosticator for cardiovascular disease." (*Albert Kattus, UCLA—Visiting Queen's Professor in Feb.*)

NOTES FROM THE MEETING WITH **TERRY ROGERS AT MABEL SMYTH, RE, HOSPITAL AFFILIATION AGREEMENT**.

Med School dean **Terry Rogers** admitted that he felt like "Daniel in the lion's den" and when he spied our vocal representative **Grant Stemmerman** in the group, he started with: "Gentlemen, ladies and Stemmy. . . ."

The preliminary draft affiliation agreement read: "Whereas the State of Hawaii will be benefited by the development of the *Area Health Education Center concept*," HMA president and moderator **Herb Chinn** asked what was meant by this concept. Terry explained vaguely that this was a concept based on the McDermott report which in turn was in the Carnegie report; that rather than the medical school being a single ivory tower, there should be units of health care and that the med school should be concerned with the community hospitals (viz the six hospitals and Tripler).

● Re, hospital internship programs, **Diek Mamiya** interjected that the internship program will be phased out in the near future and that 4th year med students will be the interns and that med students will go straight into residency after graduation. . . .

● Re, the statement: "The University shall recognize that the hospital's primary function is as a major provider of health care and community service." **Fred Reppun** commented that there were actually two concepts involved, viz university vs private practice. . . .

● Re, the status of the part-time teaching staff in hospitals. Stemmy commented frankly, "I'm operating between paranoia and deep fear. . . . Please clarify." Terry replied, "I have a footnote here. . . . 'Be nice to Stemmy.'" Instead of clarifying, however, Terry digressed into the status of the med school faculty with, "We're trying to reassure the medical community that the full time faculty will not go into private practice."

● Re, the subject of misinterpreting even very simple statements, Terry Rogers had his own little WWII anecdote to relate: "We were flying out of Edinburgh, Scotland, and asked for permission to fly in from the west coast. . . . The reply was, 'No, return over the east coast of Scotland.' The rest of the squadron interpreted this as 'No return over east coast of Scotland' and flew in from the west coast and got shot down. . . ." Fred Reppun asked, "How do you put a comma over the air?"

When there was an unusual lull after going over a portion of the agreement, Terry Rogers asked happily, "Am I to assume that the tactful silence means implicit approval?"

● Re, the paragraph, "The hospital shall appoint a full time chief of each major clinical service. . . ." Fred Reppun was explicit, "Seems to me that this is the key to the whole problem. . . ." Med School representative **Ken Gardner** tried to emphasize the concept of "togetherness" with sheer poetry, "It has to be *our* man, not *your* man or *my* man. . . ." **Gordon Liu** offered, "Why can't he be the deputy chief of service." Quccn's Chief of Staff **Ky Lum** turned to Rogers: "I told you this would happen three years ago."

Catalino Cachero's 19th Hole Repertoire . . .

A wife nagged her husband, who had been looking poorly of late, to see a doctor. The doctor told him that he had been drinking too much. On reaching home, the husband was immediately besieged by the inquisitive wife wanting to know what the doctor had said. . . . So he told her that he was suffering from "syncopation." Alas, the curious wife would not let the matter drop. She had to look up the word in the dictionary and discover that it meant "jumping from bar to bar. . . ."

A gynecologist is defined as: "The spreader of old wife's tails. . . ."

Any banker knows that a girl without principle can draw plenty of interest. . . .

"Sonovabitch . . . he cheated!" "How do you know?" "Didn't you see him hit a 3 wood out of the rough?" "Yeah, but that was a great shot. . . . That's not cheating." "But I got to his ball first and stomped it into the ground."

"You idiot! Your ball hit me in the eye. . . . I'll sue you for \$5,000." "But, but . . . I said 'fore!'" "I'll take it."

"Golf, golf, golf, Harry . . . I'll drop dead if you ever spend a Sunday at home." "Trying to bribe me, eh?" (Dedicated to nagging golf widows.)

"Hear about the terrible thing that happened to Charley?" "What happened?" "He had a terrific round on Thursday, finished early, showered and went home and found his wife in bed with another man. . . . He shot them both." "Could've been worse." "Why is that?" "If he had finished early on Wednesday, I could have been shot."

Dick and Glenn went to Las Vegas to do some golfing. . . . The loser was to pick up the tab. Dick was leading by a stroke on the last hole, but had to sink a

40-foot putt to clinch the bet. As he started to putt, a dog trotted nonchalantly in front of the cup. Without even blinking an eyelash, Dick stroked the ball in a graceful arc straight into the cup. Glenn could not contain his admiration. . . . "That was the greatest display of coolness . . . the way you didn't move a muscle when the dog ran out in front of you. . . ." "Good lord! Was that a real dog?"

Aetna Medicare Gourmet Club Meeting at M's Ranch House

Chairman **Gabe Ma** was in an unusual happy mood, having broken 80 for the first time at Mid Pac that afternoon with a sparkling 78 and four Tanomoshi's. Gabe simply exuded happiness as he introduced a new member, neurosurgeon **John Lowrey**. John's first review case was that of a craniotomy which bled later that same day. A second charge for dealing with the surgical complication was added on. John maintained that the first fee should have covered for both surgeries. . . .

Plastic surgeon **Vic Hay-Roe** had returned to the committee following his recent gall bladder surgery. . . . He pulled up his shirt and proudly displayed his scar, which we must admit was barely visible, certainly befitting a plastic surgeon. Before surgery, Vic had inked a note on his belly for the surgeon, "Please use 6-0 Nylon to close." The compulsive surgical resident had carefully stitched over 40 neat 6-0 sutures and tacked the drain into the upper end of the incision to minimize the number of scars. . . .

Internist **Gordon Liu** reviewed a case of "silicone pneumonitis," reputedly from silicone embolization from an injected breast. Vic Hay-Roe solemnly enunciated that there have been no reported cases of late embolization from silicone-injected breasts. . . . Eye man **Jerry Faulkner** quizzed, "Even after squeezing?" The two female insurance representatives were heard (you should excuse the expression) tittering. . . .

Surgeon **Henry Oyama** reviewed a multiple injury case involving four physicians, viz, an internist, an orthoped, a neurosurgeon, and a general surgeon. Henry lamented, "All four doctors worked feverishly, and when it came to charging, charged feverishly. . . . They should be sent a letter of commendation for sending in their claims promptly and simultaneously. . . ." Chairman Gabe Ma, still in good spirits, teased, "Did you have arsenic?" Oyster connoisseur **Ted Tsen** enjoined, "No oysters tonight, eh?" The patient had a cardiac arrest at 11:30 at night and though all four physicians were summoned, only the orthoped responded and Henry felt that he rightfully deserved the 2-hour detention time charged for resuscitation. . . .

To Smoke Or Not to Smoke (With Fred Greenwood)

An evening with British wit and UH endocrinologist **Fred Greenwood** of the walrus moustache is like listening to Dick Cavett, Johnny Carson, and Bob Hope at their best, all at once. We've always maintained that Britain suffered not only "brain drain," but a "humor drain" when Fred was "deported" to Hawaii. The occasion was a night at the **Grant Stemmermans** to meet his former professor, who turned out to be **Oscar Auerbach**, a friendly, gentle, slightly jowled, bespectacled intellect and wit who has none of the professorial air of someone who did all that work on lung cancer and smoking. But this did not seem to deter chain smoker Fred Greenwood, who unconsciously thumbed a cigarette and a lighter during an engaging conversation with Oscar on medical politics. . . . Or so, we thought . . . until the "Father of Lung Cancer" stared at Fred's cigarette rather menacingly and we could see Fred recognizing the error

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New Members



Ruben A. Casile, M.D.

101 Hualalai Street
Hilo, Hawaii 96720

GENERAL SURGERY

University of Santo Tomas—1954
Internship—University of
Santo Tomas—1954-1955
Swedish Hospital, Minneapolis, Minn.
—1957-1958
Residency—Swedish Hospital,
Minneapolis, Minn.—1958-1960
Swedish Hospital—1960-1963
St. Boniface Hospital, Winnipeg,
Canada—1963-1965



Philip Curd, M.D.

3420 Kuhio Highway
Lihue, Kauai 96766

GENERAL PRACTICE

University of Kentucky—1969
Internship—Evanston Hospital—
1969-1970



Leoncio T. DeJoya, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

INTERNAL MEDICINE

Santo Tomas University—1960
Internship—Mercy Hospital, Buffalo,
New York—1961-1962
Residency—Mercy Hospital, Buffalo,
New York—1962-1963
Duval Medical Center, Jacksonville,
Fla.—1963-1964
V. A. Hospital—Fort Howard,
Maryland—1964-1965



Samuel C. Y. Lui, M.D.

2313 Nuuanu Avenue
Honolulu, Hawaii 96817

ANESTHESIOLOGY

College of Medical Evangelists—1948
Internship—Los Angeles County
General Hospital—1948-1950
Residency—Loma Linda Hospital—
1960-1962

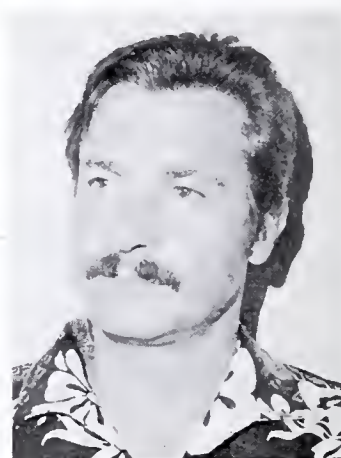


Robert Lynn Moore, M.D.

Kona Medical Associates
Kealahou, Hawaii 96750

GENERAL PRACTICE

Columbia University, College of
Physicians & Surgeons—1927
Internship—Staten Island Hospital,
N.Y.—1927-1930



Christoph J. Noll, M.D.

P. O. Box 427
Waimea, Kauai 96796

INTERNAL MEDICINE

University of Basel, Switzerland—
1959
Internship—University of Utah
Medical Center—1968-1969
Residency—University of Utah
Medical Center—1969-1971

HAWAII MEDICAL JOURNAL



Wallace Greene, M.D.

G. N. Wilcox Hospital
Lihue, Kauai 96766
GENERAL SURGERY
Stanford University—1933
Internship—Stanford-Lane Hospitals
—1932-1933
Johns Hopkins Hospital—1933-1934
Residency—Stanford-Lane Hospitals
—1934-1935
San Francisco General Hospital—
1935-1937



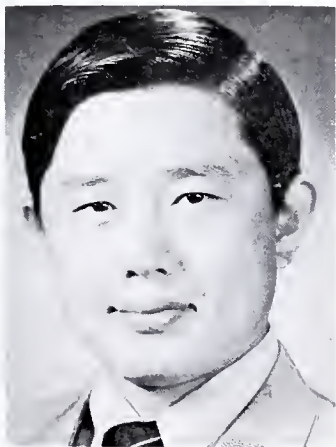
J. Brysson Greenwell, Jr., M.D.

1133 Punchbowl Street
Honolulu, Hawaii 96813
GENERAL SURGERY
Harvard Medical School—1962
Internship—Peter Bent Brigham
Hospital, Boston—1962-1963
Residency—Peter Bent Brigham
Hospital, Boston—1963-1964
Children's Hospital, Boston—
1964-1965
Peter Bent Brigham Hospital—
1966-1968
V. A. Hospital, Mass.—1968-1969



Tom A. Kendig, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
RADIOLOGY
University of Kansas School
of Medicine—1939
Internship—Henry Ford Hospital—
1939-1940
Residency—Henry Ford Hospital—
1940-1941
Letterman General Hospital—
1944-1945
Los Angeles General Hospital—
1945-1946



Moon Soo Park, M.D.

201 Kinoole Street
Hilo, Hawaii 96720
PATHOLOGY
Yon Sei University, Seoul, Korea—
1965
Internship—Hamot Hospital,
Erie, Pennsylvania—1965-1966
Residency—Hamot Hospital—
1966-1967
Cook County Hospital, Chicago—
1967-1969
Mayo Clinic, Rochester, Minn.—
1969-1971



David R. Sears, M.D.

Rt. 1, Box 214 D
Kapaa, Kauai 96746
PSYCHIATRY
Stanford—1942
Internship—Mare Island Naval
Hospital—1941-1942
Residency—Belmont Sanitarium—
1942-1946



Richard K. C. Wang, M.D.

128 Lehua Street
Wahiawa, Hawaii 96786
RADIOLOGY
National China Tun Chi
Medical School—1948
Internship—St. Francis Hospital,
Honolulu—1949-1950
Residency—Memorial Center, N.Y.C.
—1953-1955

County Society News

HAWAII MEDICAL JOURNAL

Hawaii

A regular meeting of the Hawaii County Medical Society was held at the Hilo Hotel on Thursday, February 17. Members attending included: Dr. DeWitt Smith, Dr. Paul Matsumoto, Dr. Edward Ballerini, Dr. Walter Loo, Dr. Walter Batchelder, Dr. Pete Okumoto, Dr. George Bracher, Dr. Ruben Casile, Dr. James Mitchel, Dr. Nicholas Steuermann, Dr. Richard Lundborg, Dr. Charles Hesterly, Dr. Edward Helms, Dr. Tadao Nagashima, and Dr. Marjorie Orr.

Guests present were Dr. Corbett and Dr. Michael Irwin. Guest speaker was Dr. Vaitkevicius.

President DeWitt Smith discussed the problem of communication and rapport between the Hawaii Medical Association and the County Societies. He mentioned that Mr. Tom Thorson, Executive Director, would be coming in early March to discuss these problems.

Emphasis was again given to the need to improve library facilities for Hilo Hospital physicians and physicians of outlying hospitals. It is hoped that Dr. Dick Matsuura can establish a Hawaii County Medical Foundation, the funds of which would be used for library facilities.

The Hawaii County Medical Society voted to go on record to support Senator Yoshinaga's bill, #SB1559-72, that eliminates contingency fees in medical malpractice cases.

Dr. John Brown has been approved as a member of the Hawaii County Medical Society on a vote taken at this meeting.

Maui

A meeting of the Maui County Medical Society was held at the Maui Beach Hotel, January 18, 1972.

Members present: Drs. Achong, Burden, Dietrich, Fu, Haling, Hariharan, Iaconetti, James, LaFon, Moran, Morris, Peat, Percy, Romero, Rossberg, Sowers, Uehara, Underwood, and Wong.

We missed the following members: Drs. Allred, Andrews, Azman, Behnke, Briley, Fleming, Hanlon, Howell, Izumi, Kushi, McCollum, McDonald, Moser, Ohata, Patterson, Pfaeltzer, Rockett, Strother, Tofukuji, Weeks, and Withers.

Minutes of the previous meeting as circulated were approved.

The following amendments to the Constitution and By-Laws of the Maui County Medical Society were adopted:

ARTICLE III—ELIGIBILITY

Any legally licensed (Doctor of Medicine) [physician] residing and practicing in the County of Maui, who is of good moral and professional standing. Any (Doctor of Medicine) [physician] associated with Government Service in the County of Maui, who may or may not hold Hawaii Licenses to practice, shall be eligible for inactive membership.

CHAPTER I—MEMBERSHIP

Section 1. The Society shall be the judge of the qualifications of its members, but as it is the only door to the Hawaii Medical Association and to the American Medical Association for physicians within its jurisdiction, any reputable and legally qualified (Doctor of Medicine) [physician] of Maui County shall be eligible to membership.

Section 3. Inactive membership: Members who are not eligible for Active Membership. Regular

medical officers (Doctors of Medicine) in active Government Service assigned to full duty in Maui County may be eligible to election to Inactive Membership. Application and election to Inactive Membership will be made in the manner defined under Active Membership.

CHAPTER V—COMMITTEES

Section 1. There shall be a Board of Governors [and] Standing Committees on Program and Scientific Work, on Public Health and Legislation, on Forms of Medical Practice [on Peer Review], and such special committees as may from time to time be deemed necessary.

Section 2. Board of Governors. This Board shall examine and report on the qualification of applicants for membership, subjecting each applicant to such examination as it may deem necessary. (It shall also act as the Ethics and Fees Committee. It shall investigate charges preferred against a member, and malpractice suits against members, and report its conclusions and recommendations to the Society.) In case of the absence of a member of the Board, the President may appoint some member to fill the vacancy.

Section 5. Committee on Forms of Medical Practice: This Committee shall consist of three members, appointed annually by the President.

It shall be the duty of this Committee to pass upon and approve or disapprove of any and all forms of Medical practice which may be entered into by members of the Society. It shall be its duty not only to pass upon plans submitted to it, but also to take the initiative in investigating schemes for medical service which from time to time may be proposed for groups or for the community. It shall further be the duty of the Committee to file charges with the (Board of Governors) [Peer Review Committee] of the Society against any members who persist in engaging in forms of practice disapproved by the Committee.

[Section 6. Committee on Peer Review. This Committee shall consist of the three most recent living past-presidents of the Society, plus the chairmen of its two subordinate committees *Utilization and Adjudication*. The Immediate Past-President of the Society shall act as chairman in the investigations, deliberations, and actions of this Committee. The Committee has the following responsibilities: a) Coordination of the activities of medical practice analysis in the community; b) Establishment of a pattern of accepting referral questions concerning peer review; c) Development of a method of screening county peer review materials which may require additional investigation; and d) Delineation of guidelines for quality, utilization, and fees in the community. In order to efficiently carry out these responsibilities, this Committee will delegate the tasks of primary investigation of an action upon referred cases; complaints, claims, and other review requests to subordinate committees; such as a Utilization Review Committee, an Adjudication Committee, and other subordinate committee as needed, not to exceed the state limit of 10% of the members of the Society.]

[Appeal: If either party is not in agreement with the decision rendered by the subordinate committee,

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Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

February 25, 1972 — 5:00 P.M.

Mabel Smyth Auditorium

PRESENT

Dr. Herbert Y. H. Chinn presiding: Drs. William Iaconetti, John Lowrey, R. Varian Sloan, Thomas Frisell, George Mills, William Dang, Grover Batten, H. William Goebert, Peter Kim, Ed Helms, Sakae Uehara, George Goto, Cesar deJesus, Charles Judd, Winfred Lee, Calvin Sia, Coolidge Wakai, Denis Fu, K. A. Chuang, Rowlin Lichter; members of the Bureau of Research and Planning: Chairman J. I. F. Reppun, Elisabeth Anderson, Masato Hasegawa, Wilbur Lummis, and Livingston Wong. Others were Drs. Thomas Lau, Rose Wong, Carl Boyer, Richard K. C. Lee, and Reginald Ho; Mrs. Helen Fujita; Messrs. V. Thomas Rice, Tom Thorson, Tom Leineweber and Jon Won.

CALL TO ORDER

The meeting was called to order by President Herbert Chinn.

MINUTES

Minutes of the January 7, 1972 meeting were reviewed.

ACTION:

Motion was made, seconded, and passed to accept the minutes as circulated.

COMMUNICATIONS REQUIRING ACTION

A. Letter was received from Mr. Eddie Sherman, Advertiser, requesting endorsement of a proposed Kui Lee Cancer Fund which is to lend support for an appeal for public contributions to fund cancer research projects in the community. Mr. Sherman wishes to have the blessing of the Medical Association. The proposal has received the endorsement of the University of Hawaii Medical School and the Hawaii Chapter of the American Cancer Society.

ACTION:

Motion was made, seconded, and passed that a letter expressing HMA endorsement be sent to Mr. Sherman.

B. Letter from Dr. Fred Gilbert, Straub Medical Research Institute, asking for comments and/or suggestions from the Association regarding the development of three new protocols to be submitted to the National Heart and Lung Institute to study. (1) The effect of intervention therapy in hypertension, (2) Coronary heart disease, and (3) Hyperlipidemia. These protocols were not received, however.

ACTION:

Motion was made, seconded, and passed that the President write a letter to Dr. Gilbert that we anxiously await the protocol so that it could be perused.

C. Letter from Dr. Thomas Y. K. Chang, Acting City & County Physician, requesting endorsement of Senate Bill 1613-72, relating to mobile intensive care paramedics. This bill will enable paramedic personnel to administer medications through an amendment to the present Medical Practice Act. It was pointed out that the bill was referred to both the HMA Heart Committee and Manpower Committee, but there has not been enough time to study the bill and to give an opinion or endorsement at this time on the entire bill.

ACTION:

It was moved, seconded, and passed "that HMA would like to have an opportunity to study the bill before we have an intelligent feeling about the bill."

REPORT FROM THE TREASURER

The Treasurer's Report for both December 1971 and January 1972 were submitted merely for information as they are quite lengthy and had not been circulated prior to the meeting. Action will be taken at the next meeting.

REPORTS FROM THE COMMISSIONERS AND SPECIAL COMMITTEES

A. Bureau of Research & Planning

Dr. Reppun, chairman of the Bureau, presented a report on the role of the Hawaii Cancer Commission, Hawaii Tumor Registry, and HMA's role in the control of cancer in Hawaii. This report is an outcome of a series of meetings held with Drs. Thomas Lau, Drake Will, Grant Stemmerman, John Lowrey, George Mills, Grover Batten, Richard K. C. Lee, Thomas Burch, and Messrs. George Sumner and James Bunker. The Bureau was mandated by the Council to study the overall cancer program in the State and to come up with recommendations for the Council to present to the House of Delegates meeting in May. The Bureau's report essentially recommends that the Council (1) decide under whose ownership the Hawaii Tumor Registry actually belongs and have this made clear, (2) then decide whether or not it is worthwhile to increase membership on the Cancer Commission, and (3) that HMA membership be mandatory on the Cancer Commission at least for the time being until after deliberations at the House of Delegates.

According to testimony presented to the Bureau during its meetings, it was agreed by most that the Tumor Registry is functioning well and should become even more valuable as the data is updated and computerized. It was felt that neither its base nor its functions should be interfered with at this time, but that it is essential that the Tumor Registry obtain more funds to accomplish these ends.

ACTION:

Motion was made, seconded, and passed that "the Council of the HMA reaffirms the fact that HMA inaugurated the Hawaii Tumor Registry and that it remains under the jurisdiction of the HMA."

Although increasing the membership on the Cancer Commission is not essential for proper functioning, it was felt that it might be worthwhile to increase the membership by two from the University, as requested by Dr. Lee, with the proviso that these two newly appointed members be members of the HMA.

ACTION:

Motion was made, seconded, and passed "that the Council recommend to the House of Delegates that the Cancer Commission be enlarged by the addition of two members, nominated by the President of the University of Hawaii, who are members of the HMA and who are also members of the Medical School faculty."

Dr. Richard Lee, Director, U. H. Research Corporation of Hawaii, was invited to attend this portion of the Council meeting and was asked to present the history of

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HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION CHONG, *Board of Directors:* NELLIE CHANG, WALTER HARANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, WILFRED OGOMORI and BETTY BELL.

Have You Abdicated Your Right to Self Determination As a Pharmacist?

Think carefully! Do you participate with your professional colleagues in relating to the American people how pharmacy meets and satisfies their specific medication needs? If your answer is "yes", do you communicate this acceptance of our professional service by society to the lawmakers and administrators in Washington? Are you a "do-er," a talker, a buck-passer or just too busy?

Pharmacists . . . or at least the dedicated ones . . . willing to work, to accept ridicule and perhaps even some adverse economic effects have continually struggled to gain the independence of their profession from pharmaceutical manufacturers and medical practitioners. Today finds our profession hobbled by the inequities of the Sherman Anti-Trust Act now subservient to the dictates of a third and even more dangerous foe . . . third party administrators and especially the federal government. We must move *together now* as a unified profession or be satisfied with our recognition as *technicians*.

You should not need to be reminded of the numerous injustices imposed on pharmacists, but in the interest of stimulating your personal action for unification of all pharmacy organizations into *one* powerful dedicated association capable of presenting a *united* front to all outside agencies on all major issues, I commend the listing below for your review.

1. According to the Task Force on Prescription drugs, there is an acute shortage of physicians with heavy demands placed on skills only they can provide. Yet the dispensing physician, performing a task which can certainly be performed as well by the pharmacist, continues to defer time from the application of his diagnostic expertise to encroachment on the practice of pharmacy. Why? Rarely are physicians practicing today in areas without available pharmaceutical services. There definitely is a possible conflict of interest for physicians dispensing medications or owning pharmacies.

Senator Hart alluded to this possible conflict of interest "when he stated that the Congressional Record was filled with examples of over-prescribing, over pricing and dangerous handling of drugs by dispensing physicians." Our Government has recently condoned and encouraged such dispensing practices of physicians by requiring Pharmacists to post prescription prices but exempting dispensing physicians by considering them health professionals under the economic stabilization guidelines.

Both professions, medicine and pharmacy, know that they have weak links in their professional chains. We both must police our defectors and work cooperatively to attain the best possible patient care for our community. Together—medicine by discouraging dispensers . . . pharmacy by encouraging their client-patients to check with their physicians rather than to experiment with self-medication obtained at the local grocery or self-service counter. Pharmacists are gen-

erally aware of dangerous warning symptoms of many major disease entities and can contribute meaningfully to the public welfare by directing patients to their physicians.

2. What have we done to be considered non-health professionals?

Is the development of a new service these past 10 years, the patient medication record, the reason? Doesn't seem logical since the maintenance of the patient profile allows the pharmacist to better protect the public welfare by ascertaining that the individual patient's new prescription does not contain a drug entity to which he is allergic, has no chronic illness with which the new Rx is contraindicated and is not taking another medication with which the new medication is contraindicated. During this same ten year time frame the cost of pharmaceutical services per dose of legend medications dispensed has decreased 10%. Yet, the cost of living has increased 30% and the cost of health care in general 68%. Why?

3. The Government has recognized pharmacists contributions to health care in other ways equally as devastating.

A. It has allowed third-party administrators to dictate the price for pharmaceutical services . . . yet *denies* pharmacists groups the privilege of negotiating a fair fee for their services.

B. The third party dictating the fee, then requires hours of pharmacists' time to complete cons of forms in ridiculous detail for no medical diagnostic-treatment peer review that are known to this editor . . . and for the completion of which the pharmacist is not compensated. In many instances he must then wait an unreasonable length of time for reimbursement.

C. The third party makes no distinction between pharmacies based on different dispensing costs or for time and skill differences in the preparation of compounded prescription entities. Yet numerous studies annually available support and recommend a variable fee concept.

D. The Government and the courts have effectively deleted or not enforced the Fair Trade laws . . . yet during this same period of time labor organizations have been able to achieve a high level of guaranteed wages.

4. Manufacturers are allowed to mail physicians large quantities of drug samples even though numerous investigations have indicated that the drugs are often diverted in transit or within the physician's office for other than their intended purpose.

Yet the Government inundates pharmacists with complex controls for legend drugs.

5. H.M.O. . . . health maintenance organization. Mr. Nixon proposes that these comprehensive health care centers will one day care for 90% of our population. Guidelines have been developed by NPIC to enable pharmacists to participate meaningfully in the HMO as a full professional partner of the team. If we don't unify and work together on this one, we most assuredly will become technicians. (Guidelines will be presented in the next issue).

6. Major pharmaceutical manufacturers have developed a marketing system which places an unfair burden on the pharmacist. Manufacturers are now exchanging products exploiting pharmacists through duplication as well as the double standard pricing practices to the private practitioner and teaching and government institutions.

Fellow colleagues, we had best take the time right now to think seriously about the problems confronting our profession. We have some of the best talent in the nation if we could develop its potential through one united voice . . . one for all—all for one. Why do we work such long hours to provide pharmaceutical services that we haven't time to reflect upon the vital issues that ultimately will reflect and determine our final role on the health care team?

I dare you to follow the management edict to think about the issues confronting our profession one hour per day. The conglomerate force of such concentrated effort would indeed revolutionize our image and enable pharmacy to attain its professional goals.

. . . Or do you wish to continually suffer defeats while providing a necessary service at a very little expense? It's up to you! The other fellow can't do it without *You*.

The "Fantasy" of Vitamin E

Vitamin E is a health food supplier's claim to fame. The gullible pay totally unrealistic prices for *natural* Vitamin E products from Mother Nature's famous grain stores. In return for their dollars, the public expects to cure their impotence, vascular circulation deficiencies, relieve nocturnal leg cramps, speed the healing of wounds, control their diabetes and retard the aging process.

To give false hopes of miracle cures from health food potions of Vitamin E is cruel, inhuman and inconsiderate.

The facts are that: —

1. no clinical controlled studies are available on Vitamin E.
2. there is no well-defined Vitamin E deficiency state in adults.
3. The Food and Nutrition Board of the National Research Council considers Vitamin E to be an essential nutrient in man . . . and recommends an average adult daily requirement based on the usual range of intake of 20 IU to 25 IU.

An interesting finding relative to the requirement of Vitamin E is the increased need of the Vitamin by people eating quantities of fish and liquid vegetable oils . . . unsaturated fatty acids. Adult males and pregnant and lactating females also require slightly higher dosage levels.

Only one known vitamin E deficiency effect has been reported with any reasonable consistency. Premature infants on formulas of skimmed cow's milk and vegetable oils have developed a hemolytic type of anemia. The anemia was relieved by the administration of 75 IU to 100 IU of Vitamin E daily. No adverse hematologic effects have ever been observed in adults.

There have been no reported toxic effects to Vitamin E but let us remember to reply to queries from our patients who may have read testimonials per se to the contrary, that there is *no* information in the scientific literature establishing any value for the utilization of Vitamin E in preventing or treating any human disorder.

Pentazocine HCl—Dependence—Abuse (Talwin-Winthrop)

Recent reports of pentazocine abuse should stimulate we pharmacists to view our patient medication profiles with increased concern, relating our information of a patient's possible drug misuse to the attending physician.

Patients receiving the drug following surgery often require gradually increased and more frequent doses of the drug to maintain the required analgesic effect. In addition to this tolerance effect, some patients on the drug have shown some personality disorders that may or may not be related to the drug. Abstinence symptoms have been viewed and relieved with the oral pentazocine.

In actual fact only 130 reports of *alleged dependence* of the drug have been reported in the 211 million doses administered. This excerpt is intended to assist a drug with a good record by warning pharmacists that there does seem to be some dependence potential to pentazocine provided the circumstances of personality, dosage, availability, etc. are present. Be observant!!

Folic Acid

New information on Folic Acid levels required for the treatment of deficiencies have resulted in the removal of the 20 and 5 mg tablets from the market. You are reminded that *only* 1 mg tablets will be available in the future.

It was recently found that Folic Acid deficiency treatment of patients on dephenylhydantoin anti-convulsant therapy resulted in loss of seizure control. Patients stabilized on anti-convulsants should receive Folic Acid therapy only if absolutely necessary and with attending biochemical serum level studies to prevent loss of stabilization. Obviously discontinuance of Folic Acid therapy in such a situation could result in drug intoxication.

New Products

Versapen-K capsules 225 mg. (Potassium Hetacillin, Bristol).

Versapen Oral Suspension 112.5 mg/5 ml, 80 ml and 100 ml bottles.

Versapen-K *IV* 225 mg & 450 mg; to be reconstituted with 5 ml or 10 ml Sterile Water for Inj. and used within 6 hours.

Versapen-K *IM* 225 mg & 450 mg with Lidocaine (Xylocaine). Reconstitute with 1 or 2 ml Sterile Water for Inj. and use within 6 hours.

Potential use of hetacillin is indicated whenever ampicillin could be used. In fact, the antibiotic effect of hetacillin results from its conversion to ampicillin; 1 mg hetacillin producing slightly less than 1 mg ampicillin. The Medical Letter (June 11, 1971; pp. 49-50) states that any claimed advantage of hetacillin over ampicillin is unfounded. Considering cost, Versapen products in all dosage forms are more expensive than equivalent doses of ampicillin.

Trobicin IM Injection (spectinomycin, Upjohn) is a new antibiotic used in the treatment of acute gonorrheal infections in both men and women. It is not effective in treating syphilis, therefore patients in whom syphilis is suspected should be closely watched clinically and have monthly serological check-ups for 3 months or longer. Safe use in pregnancy and in infants and children has not been established. Trobicin IM is available in vials containing 2 Gm. or 4 Gm. spectinomycin powder and is reconstituted with Bacteriostatic Water for Inj. The suspension contains 400 mg spectinomycin equivalent per ml. It should be stored at *Room Temperature* and used within 24 hours. *Usual dose for Male Adult:* a single 2-4Gm. (5-10 ml) IM dose, which may be divided between two gluteal injection sites. *Female Adult:* single 4 Gm. (10 ml) IM dose, may be divided between two gluteal sites. Certain laboratory tests could be affected by Trobicin. For information concerning this, consult the product insert.

of his ways, surreptitiously palm the cigarette and lighter into his pocket. . . . Oscar graciously acknowledged this gesture with, "Well, that's better."

Later, with Oscar safely tucked away in another dining area and Fred smoking like a stove pipe, we had the temerity to ask Fred how much he smoked. We were treated to a typical Greenwoodism: "I smoke 1 pack, but I buy 2 packs a day." He then related his hilarious experience with a smoking withdrawal clinic sponsored locally several years ago by the American Cancer Society. Psychologist **Ray Corsini** finally gave up and branded him as suffering from an "Adolescent Childhood Syndrome" (which according to Fred is characterized by 'you know what you want, and how to get it, and you want it now'). Fred recalls that out of his group of 12 confirmed smokers, the only success was his partner, a hair dresser, who was supposed to call him for support whenever she craved a smoke. Fred couldn't be bothered so he simply left word with his secretary that whenever she called, which was quite often, she was to be informed in no uncertain terms that "he didn't give a damn whether she smoked or not and that she should go ahead and smoke all she wanted to." Oddly enough, the hair stylist cut down her need from 50 cigarettes a day to 10 which was a howling success. . . . At this point Kuakini Cancer Research Program's **Gary Glover** (who has acquired some of the British wit with his recent stay in England and his marrying an English girl) remembered a joke about smoking. . . . "A researcher was making a survey about smoking and asked this woman if she smoked after sexual intercourse. . . . She replied quite matter of factly that she didn't really know because she had never looked. . . ."

We were relieved to learn that Fred whose forte is breast cancer does realize that smoking is harmful, and that his own flesh is weak. Fred does feel however that any antismoking campaign be directed at the kids not adults . . . and for this reason, he never offers his precious cigarettes to others . . . esp. to youngsters. . . .

Conference Dialogue

A 52 year old man with plasma cell myeloma had 4 plus albuminuria and no azotemia. Moderator **Noboru Oishi** was curious: "How are you planning to treat?" **Tom Fujiwara** smirked, "I just want the experts' opinions. . . . Whether to go all out or not." **Quint Uy** offered, "Corticosteroids plus alkylating agents." Tom: "Hit hard when his white count is only 1,000?" Quint: "Yes, give the full dose regardless of the count." Noboru asked, "How about intermittent therapy?" **Grant Stemmerman** was more interested in the renal picture: "I think this is a nephrotic kidney secondary to tubular plugging, rather than a typical myeloma kidney, because there is no azotemia." Quint added, "It'll be interesting to do an electrophoresis of the urine." Noting that radiologist **Carl Boyer** was dozing through all this, Noboru demanded, "Carl, don't just sit there . . . Say something." Carl, shaken out of his somnolence: "Hi!" Grant teased, "Say total body radiation." Grant was hopeful, "I've seen 2 cases of spontaneous remission of malignancy and one of them was a myeloma case." Quint commented: "Someone's slipping some Chinese herbs. . . . Maybe this is a Krebiozen cure." Tom was impatient: "What's the recommendation of this group?" So Quint concluded, "Full dose of steroids and a alkylating agent. There's a 50% chance of responding."

A 70 year old Japanese man with Stage I carcinoma of the stomach had surgery. **Takakazu Fukumura**, proud of his gastroscopic color slides, showed countless slides of the early changes of the antrum and stated that he had taken 11 biopsies with 3 positives. Quint Uy was duly impressed with the slides, "Looks like the moon," he said. Stemmy enthused, "With Stage I, there is a 95% survival after 10 years. We've had 3 such early CA's in the past week." He further emphasized the need for

multiple quadrant biopsies of the bordering mucosa and that any individual being treated for chronic gastric ulcer should have a good gastroscopy. Noboru Oishi protested faintly, "But the yield was only 3 out of 11 biopsies." Takakazu reported, "The Japanese endoscopy survey report indicates that it is not related to the number of biopsies, but where you take it."

The discussion shifted to the value of gastric cytology and Grant stated, "As to cytology, the intestinal type can be diagnosed early, but the diffuse type cannot. Japan has the intestinal type and here, we have the diffuse type." Takakazu quizzed, "Is your technique good?" Grant was frank, "I don't have too much confidence with cytology. You can't make a diagnosis with cytology." Takakazu countered with: "But the Aichi Cancer Center emphasizes cytology."

Grant repeated, "Those with recurrent symptoms and repeat GI series should have gastroscopy with quadrant biopsies because they are the ones with early CA." But surgeon **Roy Tanoue** was not impressed, "I would do surgery without waiting for gastroscopy," he said.

A 59 year old Hawaiian man with gastric CA had liver metastasis. . . . Grant commented, "He has the intestinal type, a typical Hawaiian tumor and should be treated with all the poisons and in large amounts." **Vic Mori** commenting on the possible etiology whispered to us, "Must be the lomi salmon." Noboru Oishi asked, "What combination would you use?" Quint Uy suggested, "5 FU mixed with poi. . . ." Grant was more explicit: "Our visiting professor (referring to tutor oncologist Dr. Vaitkevicius) recommended 5 FU with combination "proven" drugs . . . I don't like the term. . . . But we have to have a combination protocol. We cannot wait for others . . . We have to start the protocol in this hospital. . . ."

A 68 year old man who enjoyed smoking had extensive surgery for carcinoma of the kidney and the bladder. Pathologist Grant Stemmerman added the *coup de grace* with: "I think he should stop smoking. There is increasing evidence from Japan that bladder cancer is associated with smoking."

A 57 year old man with carcinoma of the lung and widespread metastasis to the chest wall, positive scalene nodes and possible liver metastasis was a 2 pack smoker for many years and an alcoholic to boot. **Melvyn Kaneshiro** described the patient as fairly amenable to chemotherapy, but that his liver enzymes were up from his drinking. Grant wondered, "With his liver status, I wonder if he is a candidate for Bleomycin?" **Carl Boyer** was more practical: "Do as little as possible. . . . You know the definition of an alcoholic is 'someone you don't like who drinks more than you.' As a non-oncologist, may I suggest that he be given his alcohol." Grant conceded, "I agree."

At a Queen's Friday morning panel discussion, **Ken Gardner** was giving the differential diagnoses for a 43 year old Hawaiian Chinese man admitted with increasing shortness of breath, swelling of his ankles and abdomen, and paroxysmal nocturnal dyspnea with a questionable history of rheumatic fever, who has been taking digoxin and "water pills" sporadically. With typical med school mumbo jumbo, Ken Gardner was saying, "Strauss lists 139 cases of nephrotic syndromes and the first is idiopathic." After he digressed even further on the subject of edema, **Jim Orbison** became impatient: "We've gone through the nitty gritty diagnoses. Now give us a gut feeling diagnosis. . . . Heart failure or amyloidosis? Ken emitted a hearty grunt and declared, "Heart failure."

Lockerroom Anecdotes

Frederico had recently arrived from the Philippines and heard so much about the famous Michelob beer that he was anxious to try it. While lunching at a Japanese

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the proposed cancer program from its inception and to answer questions raised by the Council. During the discussions, Dr. Lee urged HMA to be actively involved in the planning stage of the cancer program in the State and especially in the composition of membership on the Executive Board and its other committees. It was urged that all organizations involved in the cancer program work together in a concerted effort in these planning stages for the establishment of the cancer project in the State of Hawaii. The discussions produced several actions.

ACTION:

Motion was made, seconded, and passed "that our representative on the Ad Hoc Policy Task Force of the Cancer Research Center be directed to request or work toward community representation on the Executive Board."

ACTION:

Motion was made, seconded, and passed "that the Council direct the HMA President to write to the U. H. President stating the action which it has taken regarding composition on the Cancer Commission and that we feel that the Executive Board of the Cancer Research Center should be truly community oriented." A copy of this letter to be sent to Dr. Lee.

B. Public Health

Ad Hoc Committee on Drug Abuse: Commissioner Dr. Sia reported that Dr. Charles Stewart and Dr. Neal Winn have been appointed to the Governor's Committee on Substance Abuse. (Dr. Winn was elected chairman of this committee on February 25.) The HMA Ad Hoc Committee feels that the Association should play a strong role in drug abuse programs and decisions of the State. The Committee recommends that it be changed from an ad hoc committee to a standing committee and change its name to "Committee on Substance Abuse."

Water Safety: The Mayor's Water Safety Committee asked for physician volunteers from the Association to serve on the Mayor's Committee on Water Safety. Notice of this request will be published in the Newsletter.

C. Legislation

Legislative Committee: Dr. Goto reported that the committee is working on the Statute of Limitations with the assistance from Mr. Ben Kaito. This particular legislation is currently locked up in the Senate Judiciary Committee. Another area in which the Legislative Committee is working on is in drawing up a bill which will create compulsory arbitration for malpractice. It is to be modeled after the Minnesota and New Jersey laws.

D. Medical Services

Workmen's Compensation: Dr. Albert Chun-Hoon and Dr. William Dang have been appointed by the President to serve as co-chairmen of the Workmen's Compensation Committee in the absence of Dr. Theodore Tomita. It was reported that the committee is working on an amendment to the Law in the establishment of a base law. This appears acceptable to Mr. Hasegawa who is in favor of this concept.

E. Nominating Committee

The Committee met on February 11, 1972 under the chairmanship of Dr. Livingston Wong and came up with the following nominations for the House of Delegates: President Elect—Thomas P. Frissell; Secretary—R. Varian Sloan and Ann B. Catts; Treasurer—Grover H. Batten and K. S. Tom; and Councillors from Oahu (two to be elected)—H. William Goebert, Jr., George Goto, and J. I. F. Reppun.

NEW BUSINESS

A. Peer Review

President Chinn asked the County Presidents to appoint a representative from their respective county Peer Review Committees to the State Peer Review Committee,

and also to submit guidelines established for their committees. This request was made in view of the 1971 House of Delegates action approving a recommendation from the Medical Care Plans Committee to set up, with suggested guidelines, a Peer Review Committee. (See report of the Medical Care Plans and Peer Review, HAWAII MEDICAL JOURNAL, July-August, 1971, p. 322.) Composition of the State Peer Review Committee, as recommended and approved, would include the chairman of the HMA Medical Care Plans Committee, the HMA Commission on Medical Services, and one member from each of the county Peer Review Committees.

B. President's Assistant

Dr. Elisabeth Anderson has been appointed Assistant to the President. It was reported that Dr. Anderson has been most effective in this role by keeping the President and officers abreast of current activities and by representing the Association at numerous meetings. It was recommended that consideration be given to changing the position to Executive Vice President. However, it was discussed that this may be the function of the Executive Board and no action was taken.

C. Emergency Medical Service

The President reported that RMP is now moving into the Study of the Delivery of Health Care in Emergency Areas. In the area of Emergency Medical Service, the acting chairman is Dr. Mor McCarthy. With Dr. McCarthy's leadership, there is expected to be involvement from the community with participation from the entire State including all counties. Prospects of funding for this portion of the Study seem very likely to come from the Department of Defense.

D. Joint Evaluation Study of DSS and Kaiser

Mr. Won reported that an evaluation study is in progress on a joint project of the Hawaii State Dept. of Social Services (DSS) and the Kaiser organization which is designed to measure the care given to welfare clients by Kaiser. Basically, this project involves some 500 families in the Leeward, Wahiawa, Windward, and Kalihi-Palama areas. There are three sections to this study project: (1) an evaluation of the utilization of services and the quality of care received by this group from the Kaiser organization compared to care received by welfare clients from private practitioners—Investigator: Dr. Robert Worth, School of Public Health; (2) an evaluation of the public health education aspects delivered by "outreach" workers—Investigator: Dr. Jerry Grossman, School of Public Health; and (3) an evaluation of the impact of consumer participation on the functioning of this program—Investigator: Mr. Larry Koseki, U. H. Research Corporation.

This project is being funded by Dept. of Health, Education, and Welfare to the tune of \$144,000 over a period of 18 months. An advisory committee has been formed which is responsible for the progress of this evaluation study and for making the final report to Washington, D. C. Representation on this committee involves six from Kaiser, five from the School of Public Health, three from DSS, four from the social and economic community, and, originally, none from organized medicine. At Mr. Thorson's request, one representative from HCMS has been invited to sit on this committee. Because of the shortness of notice and the date and time, Mr. Won sat in on this first meeting. Dr. Worth has submitted his proposal on the evaluation of utilization and quality of care given to DSS clients in this project to the HMA for endorsement. Dr. Fred Reppun, Chairman of our Bureau of Research & Planning, has been asked by Dr. Worth to review this proposal. It should be mentioned that this portion of the project proposes to utilize EMCRO criteria. This subject was brought to the Council for information only at this time. This project will be closely followed.

ADJOURNMENT

Meeting was adjourned at 11:30 p.m.

R. VARIAN SLOAN, M.D.
Secretary

restaurant one day, he asked a neophyte waitress in his strong Filipino accent, "I want Michelob." The young waitress looked shocked and promptly retired to the kitchen and would not come out. . . . Frederico waited and waited for his beer and finally hailed another waitress. . . . "Where's my Michelob?" The second waitress sighed with relief, "Oh, so that's what you really wanted. . . ." (Contributed by **George Suzuki** who claims this really happened—only the names have been changed to protect the innocent).

A fellow in town was successfully impersonating a physician until he made the fatal mistake of making a house call. . . . The local authorities immediately became suspicious and the impersonation was uncovered. . . . (Another Suzuki anecdote).

Life In These Parts

"A policeman called the owner of a stolen car to report, 'I have good and bad news for you. First, the bad news—your car went out of control on the Pali Hwy., and crashed. The good news—it was getting 40 miles per gallon.'" (As told by **Ralph Beddow** to **Kathryn Murray** and retold by her to **Eddy Sherman**).

Tomi Knaeffer's article, "Flu Fells Isles' Top Bug Fighter" featured **Ira Hirschy**, our State Health Dept. Communicable Disease chief. It appears that Ira did not see a physician when he was down with the flu and did not have his case reported to his epidemiology staff. Tomi chastises, "He chuckled and one could almost feel him blushing for failing to practice what he often preaches." Another recent flu victim was **George Mills**, the only physician in the State Senate who missed a week of work in February. (Osler: *The physician who treats himself has a fool for a patient*).

School Board Chairman **Dick Ando** was featured in the *New York Times* recently. "His father delivered ice to homes and shops until electric refrigeration became widespread." Dick, proud of his humble beginnings, said, "That ice wagon put me through college. . . ." (We remember Dick as the top sports editor for the *McKinley Daily Pinion*).

When a *Star-Bulletin* reporter made a random survey of local physicians for hangover cures, he got answers like, "There is no such animal." "What can you do to get rid of that cotton-mouth-big-head-upset-stomach-feeling?" "Nothing." "Suffer, baby, suffer." One physician offered, "Anything with salicylic acid; that'll fix em up," but went on to preach, "But don't drink—that's the best thing." Another felt that "Aspirin or black coffee in combination with alcohol has a tremendous inflammatory response in the stomach or duodenum." "What about going for a swim?" "Swimming doesn't help." "What about Bloody Mary or aspirin?" "Lay people take a lot of different things that they think help them, but I don't know if they really work."

The nationwide AMA membership dropped below 50%, but not so in Hawaii. HMA executive secretary **Tom Thorson** reports that 850 or 74% of the 1,150 eligible physicians licensed in the State are AMA members. The reasons why the remaining 26% are not members seem to vary. There were 77 newly licensed physicians in the State last year and an equal number of new AMA members. . . . (Osler: *The Society should be a school in which the scholars teach each other*. . . .)

Columnist **Dave Donnelly** reports, "The TV show 'Medically Speaking' is pau on Channel 11 and will be replaced in part by a monthly program tentatively called 'Pets and Vets.'" (Auwe! Replaced by Vets.)

During his term as HMA president, neurosurgeon **John Lowrey** proposed the concept of "death with dignity," and this is now before the legislature as HR 44, which provoked some religious objections because of the unfortunate use of the term "euthanasia." In February, **Bishop John Scanlan** clarified the Catholic Church's

stand that "the Church does not believe it is necessary to go to extraordinary means to preserve human life, though such means may be used if desired." On the use of drugs to suppress pain and suffering, another Catholic source says that drugs are perfectly acceptable so long as the purpose is to relieve pain and suffering and not to induce death. A *Star-Bulletin* editorial comments, "Such a bill can be drafted without either legalizing murder or giving religious offense."

But then, John received the unqualified support of the Honolulu Memorial Society. The president of HMS wrote, "Hopefully, we may yet see the day when 'The Living Will' is valid in this State and will ease the passing of terminally ill patients." (Conflict of interest?)

The cost of medical care for the poor in Hawaii climbed \$6.8 million from \$16.8 million in 1970 to \$23.6 million in 1971. There is one doctor for every 850 residents on Oahu, but only one for every 1,400 residents on the neighbor islands. **George Mills** feels that the state government failed to follow up on the recommendations of Greenleigh Associates, made in March, 1970, which urged standardization of drug formularies and prices and urged the use of facilities for intermediate care for many patients who occupy intensive-care beds at higher costs.

When city councilwoman **Mary George** pushed for legislation against fireworks, the HMA's environmental health committee withheld support. **Leigh Sakamaki** wrote: "We feel it is 'Lilliputian' in comparison with the critical health hazard created by the largely accepted ritual of welcoming the New Year by blowing our collective minds on alcohol. . . . Some people welcomed in New Year at the Sunshine Festival—paying tribute to nature and their fellow man. Others chose to welcome the New Year prostrated in bed, hung-over, their minds pickled in alcohol and, as Councilwoman George has already pointed out, their lungs choking on firecracker smoke, if not already choked on tobacco smoke. But let's take our problems in the order of priority."

A UH survey revealed that in the first year of legalized abortion, one out of every 60 women of childbearing age in Hawaii had an abortion; that one out of six pregnancies ended in abortion; that the total number of abortions was 3,643 or an average of 10 a day; that 87% of the abortions were performed in the first 12 weeks of pregnancy and only 1% after more than the 20th week; that 90% of the abortions used the D&C suction technique while saline infusion or "salting out" was used in 10%; and that the complication rate was less than half the national average.

"No Housing Problems for Ukus." The Kauai Dep. of Health is faced with the problem of ukus (lice) in long-haired boys. **Richard Cardines**, district health officer was sympathetic: "Ukus are nothing so very terrible. . . . They are more of a pest and nuisance, and do not carry disease. For many cultures, body lice is no big thing. . . . It all comes within the cultural framework. . . . The middle class attaches a stigma to ukus and children are hurt because ukus imply lack of cleanliness. . . ."

Elected, Appointed, and Honored

On the medical front, **George Mills** was appointed to the Council of Legislation and **Robert Moser** reappointed to the Council on Drugs; both councils are standing committees of the AMA's Board of Trustees. **Albert Ho** was elected president of the Hawaii Chapter of the American College of Surgeons while **Ed Lau** was elected vice-president, **Carl Mason** secretary-treasurer, and **Roy Tanoue** and **Col. Alfred Kent** councillors. **Sau Ki Wong** has been reelected president of the Hawaii Association for Eye Safety, and **Thomas Maeda, Jr.** auditor.

On the community front, RMP's **Masato Hasegawa** was elected one the five vice-presidents of the Aloha United Fund at its sixth annual meeting and **Paul Tamura** to the board of directors. Masato was also elected to the 1972 board of directors of the Chamber of Commerce of Hawaii. **Robert Bart, Jr.** was reelected

continued page 136

HAWAII MEDICAL ASSOCIATION

116th ANNUAL MEETING--1972

Ilikai Hotel—Pacific Ballroom—Honolulu, Hawaii

THEME: "PATHOLOGY AS IT RELATES TO CLINICAL PRACTICE"

PRELIMINARY SCIENTIFIC PROGRAM

TUESDAY, MAY 9, 1972

MORNING

- 7:30 AM Call to Order by Herbert Y. H. Chinn, M.D., President
Welcome by R. Varian Sloan, M.D., Chairman, Arrangements Committee
- 7:45 AM "The Panorama of Hepatitis, Viral and Other"—Edward A. Gall, M.D.
- 8:15 AM Intermission to view exhibits.
- 8:45 AM Session A:—"The Pathogenesis of Cirrhosis"—Edward A. Gall, M.D.
Session B:—"The Fibrinolytic Function of Eosinophils and Their True Role in Allergy"
—John W. Rebuck, M.D.
Session C:—"Laboratory Service to the Patient on Admission"—Harry H. Marsh, M.D.

AFTERNOON

- 1:00 PM House of Delegates

EVENING

- 8:00 PM FIRESIDE CHATS (Hawaii Thoracic Society)
(Exhibits will be open.)

WEDNESDAY, MAY 10, 1972

MORNING

- 7:30 AM "Tumors of the Head and Neck—Case Presentations"—William O. Russell, M.D.
- 8:00 PM Intermission to view exhibits
- 8:30 AM Session A:—"Tumors of the Head and Neck—Case Presentations"
—William O. Russell, M.D. — (Continuation)
Session B:—"Liver Biopsy in the Evaluation of Neonatal and Infantile Obstructive Jaundice"
—Jay Bernstein, M.D.
Session C:—"Emergency Room Toxicology"—Harry H. Marsh, M.D.

EVENING

- 7:00 PM "The Contributions of the Necropsy to Medical Progress"—Edward A. Gall, M.D.
- 7:45 PM Intermission to view exhibits
- 8:15 PM Session A:—"Renal Insufficiency in the Newborn"—Jay Bernstein, M.D.
Session B:—"New and Old Diseases of Basophils and Mast Cells, Ulcerative Colitis, Hunner's Ulcer, Penicillin Sensitivity and the Mucopolysaccharidoses"—John W. Rebuck, M.D.
Session C:—"Laboratory Diagnosis of Anemia"—Harry H. Marsh, M.D.

THURSDAY, MAY 11, 1972

MORNING

- 7:30 AM "Ultrastructural Diseases of Platelets, a Common Cause of Unexplained Bleeding in Everyday Practice"—John W. Rebuck, M.D.
- 8:00 AM Intermission to view exhibits.
- 8:30 AM Session A:—"Renal Biopsy in the Idiopathic Nephrotic Syndrome of Childhood"
—Jay Bernstein, M.D.
Session B:—"Current Status of Antimicrobial Susceptibility Tests and Their Utilization in Medical Practice"—Harry W. McFadden, Jr., M.D.
Session C:—"Diagnosis and Treatment of Pulmonary Embolism"—Harold Israel, M.D.

AFTERNOON

- 1:00 PM House of Delegates

EVENING

- 7:00 PM "The Enigma of Asthma"—Harold Israel, M.D.
- 7:30 PM Presidential Address—Herbert Y. H. Chinn, M.D.
- 7:45 PM Address by AMA President—Wesley W. Hall, M.D.
- 8:00 PM Intermission to view exhibits
- 8:30 PM Session A:—"Selection of Antibiotics and Laboratory Monitoring of Treatment in Bacteremia"
—Harry W. McFadden, Jr., M.D.
Session B:—"Tuberculosis Revisited"—Harold Israel, M.D.
Session C:—"Therapeutic Significance Of Histologic Types of Primary Thyroid Carcinoma: A Clinicopathologic Study of 777 Patients"—William O. Russell, M.D.

FRIDAY, MAY 12, 1972

MORNING

- 7:30 AM "Complications of Antimicrobial Therapy—bacterial Resistance, Superinfections, and Toxicity"
—Harry W. McFadden, Jr., M.D.
- 8:30 AM Session A:—"Some Practical Aspects of Antimicrobial Agents and their Mechanisms of Action on Pathogenic Microorganisms"—Harry W. McFadden, Jr., M.D.
Session B:—"What the Physician in Family Practice Needs and Expects from the Pathologist"
—Marolyn M. Cowart, M.D.
Session C:—To be scheduled.

ANNUAL SPORTS AND SOCIAL EVENTS

Bow & Arrow Hunting Tournament—May 5-7, 1972—Island of Hawaii
Tennis Tournament—Ala Moana Courts—April 23, 29 & 30, 1972
Deep Sea Fishing Tournament—May 7, 1972—Honolulu
Skin Diving—April 22-23, 1972—Kalaupapa, Molokai
Golf Tournament—May 12, 1972—Francis H. Brown Golf & Country Club
Sixth Annual Sportsmen's Night—May 13, 1972—Natsunoya Tea House
Woman's Auxiliary Annual Meeting & Luncheon—May 12, 1972—Sheraton-Waikiki Hotel
Annual Banquet—May 12, 1972—Pacific Ballroom, Ilikai Hotel

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

HOUSE OF DELEGATES MEETINGS

Tuesday, May 9, 1:00 P.M.
Thursday, May 11, 1:00 P.M.
Pacific Ballroom—Ilikai Hotel

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

GRATEFUL ACKNOWLEDGEMENT IS MADE TO THE FOLLOWING ORGANIZATIONS WHO MADE THE PROGRAM POSSIBLE

American Cancer Society, Hawaii Division, Inc.
Bristol Laboratories
Burroughs Wellcome & Company, Inc.
Ciba Pharmaceutical Company
Geigy Pharmaceuticals
Hawaii Heart Association
Hawaii Thoracic Society
Parke Davis & Company
A. H. Robins Company
Sandoz Pharmaceuticals

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

GUEST FACULTY

Wesley W. Hall, M.D.
President, American Medical Association

Jay Bernstein, M.D.
Director, Anatomic Pathology
Beaumont Hospital
Royal Oak, Michigan

Marolyn M. Cowart, M.D.
Private Practice
Houston, Texas

Edward A. Gall, M.D.
Director of the Medical Center
University of Cincinnati
The Medical Center
Cincinnati, Ohio

Harold Israel, M.D.
Clinical Professor of Medicine
Jefferson Medical College
Philadelphia, Pennsylvania

Harry H. Marsh, M.D.
Clinical Pathologist
Wesley Medical Center
Wichita, Kansas

Harry W. McFadden, Jr., M.D.
Professor and Chairman
Department Medical Microbiology
College of Medicine
University of Nebraska Medical Center
Omaha, Nebraska

John W. Rebuck, M.D., Ph.D.
Chief, Division of Laboratory Hematology
Henry Ford Hospital
Detroit, Michigan

William O. Russell, M.D.
Head, Department of Anatomic Pathology
The University of Texas at Houston
M.D. Anderson Hospital and Tumor Institute
Texas Medical Center
Houston, Texas

140/90 is normal blood pressure...or is it?

An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

Study Findings. Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"¹—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.

- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

Other Studies. Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"² and the "Framingham Study"³—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

Another Point of View. Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol



levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"⁴ Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."

Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

MSD
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DOHME

25- and 50-mg tablets

HydroDIURIL[®]
(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," *JAMA* 213:1143-1152, Aug. 17, 1970.
3. Kannel, William B., et al., "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," *JAMA* 214:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M., "What's With Hypertension These Days?" *Consultant*, Jan. 1971.

HydroDIURIL[®]

(Hydrochlorothiazide|MSD)

Therapy to Start With

Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

PRECAUTIONS: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to

myocardial activity. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Hypochloremic alkalosis occurs infrequently and is rarely severe. In severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur if dietary salt is unduly restricted, especially during hot weather.

Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics.

Pathological changes in the parathyroid glands with hypercalcemia and hypophosphatemia have been seen in a few patients on prolonged thiazide therapy. The effect of discontinuing thiazide therapy on serum calcium and phosphorus levels may be helpful in assessing the need for parathyroid surgery in such patients. Parathyroidectomy has elicited subjective clinical improvement in most patients, but has no effect on hypertension. Thiazide therapy may be resumed after surgery.

Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. May affect insulin requirements in diabetics; may induce hyperglycemia and glycosuria in latent diabetics.

ADVERSE REACTIONS: Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, cholestasis, and pericholangiolitic hepatitis. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, transient blurred vision, sialadenitis, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have linked thiazides to pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. When adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn.

For more detailed information, consult your MSD Representative or see the Direction Circular, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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medicine is not a cut-rate field.

Too much is at stake to cut corners by cutting service. At Amfac you will find the lowest prices and the best terms consistent with the service you deserve and the standards you demand. Large, local stock. Fast, dependable four-times-a-day delivery service. 30 days to pay.

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Drug Department
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chairman of the Medical Advisory Committee of the Hawaii Chapter of Muscular Dystrophy Association. **Elizabeth Anderson** was elected vice chairman of the Advisory Council of the Hawaii Chapter of the National Multiple Sclerosis Society and **Mike Okihiro** was reelected to the board. **Robert Chung** was elected vice chairman of the Honolulu Police Commission.

Burt Wade recently retired from active practice after serving Kauai in many capacities since 1934. In a short sincere speech, the administrator of the Kauai Veterans Memorial Hospital thanked Burt for "his many years of cheerful concern as well as his doctoring."

Professional Moves

The Year of the Rat is a time for timidity and meanness, a time for good international relations (perhaps Nixon in making his China trip consulted his own astrologers) and also a time for poor connubial bliss. In January, plastic surgeon **Robert Flowers** left Straub and opened his office at the Pacific Insurance Building, 677 Ala Moana and another Straub man, ophthalmologist **Perceval Chee**, relocated to Alexander Young Bldg. and to 94-750 E. Hikimoe St., Waipahu. Replacing them at Straub were ophthalmologist **Leonard Kuninobu** (Jimmy's son) and plastic surgeon **James H. Penoff**. ENT man **Walter Yokoyama** left Waikiki to the tourists and moved to the Pan Am Bldg. at 1600 Kapiolani Blvd.

In February, plastic surgeon **John Brown** moved to 327 Kinoole, Hilo; GP **Wing S. Pong** opened his clinic at 91-843 Fort Weaver Road, Ewa Beach; psychiatrist **J. Mathews Robison, Jr.** opened his office at 1441 Kapiolani Blvd.; thoracic surgeon **J. Judson McNamara** relocated to Harkness Pavilion, Queens Medical Center; and urologist **James A. Dow** opened at Pacific International Bldg., 677 Ala Moana Blvd. The big news was the merger of three prominent internists, **Winfred Lee**, **Chew Mung Lum** and **Roger Ogata** as the "Internist Clinic, Inc." at 1441 Kapiolani Blvd. On Kauai, OB Gyn man **Patriek Aiu**, one of the eight children of the **Eugene Aiu's** of Kapaa, went home to join the medical staff of Wilcox Hospital where he was born 33 years ago. He noted that things have changed greatly since then. . . .

Quotable Quotes

Harry Arnold, Jr. wonders, "Is Noh business like show business?" Harry also asks, "I wonder where's Kissinger now." With typical Arnold curiosity, he questions the report, "The bullet is in her yet." "Where is a woman's yet?"

Hors De Combat

When we note how illegible our prescriptions have become of late, we worry about the significance of the recent article, "Wrong Pill Pops \$6 Million Suit." It seems that a Mrs. Stanley Kuhns of R.L. got a prescription from her physician for Norelestrin. The pharmacist misread it and gave her a supply of Novohistine which she took faithfully. She went back for a refill and for the third refill, the husband stopped at another drug store where the pharmacist called the first pharmacist for verification. Notwithstanding the nasal decongestant effects of Novohistine, Mrs. Kuhns became pregnant and gave birth to a boy. The Kuhns filed suit against the two pharmacists, but, oddly enough, not against the physician whose illegible handwriting must have started the whole fiasco. The justice dismissed 3 million dollars worth of claims, but another 3 million dollars are pending. Mrs. Kuhns claims \$1 million for alleged violation of her constitutional rights not to have more children, \$250,000 for alleged pain, suffering and anguish from getting the wrong pills and \$750,000 to raise her son to adulthood. . . . (Methinks we better start writing more legibly. . . .)

continued page 140

Gantrisin® (sulfisoxazole) Roche® provides your patients with many important advantages:

- high urinary levels
- generally good tolerance
- high solubility at average urinary pH
- rapid absorption
- rapid renal clearance
- high plasma concentrations
- economy (average cost of therapy: less than 6½¢ per tablet)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in pregnancy has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

acute, recurrent or chronic nonobstructed cystitis

TWO BUILT-IN BENEFITS OF GANTRISIN[®] sulfisoxazole/Roche[®]

1.

High urinary drug levels

Gantrisin quickly reaches peak antibacterial concentrations in the urine — usually in 2 to 3 hours. With the recommended dosage regimen, Gantrisin maintains these high urinary levels throughout therapy to combat such susceptible organisms as *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

2.

Generally good tolerance

Because of Gantrisin's high solubility and rapid excretion, therapy is relatively free of adverse reactions serious enough to require discontinuance of the drug (3.1% of 1002 patients in a recent study*). Even minor reactions are comparatively infrequent, but may include nausea, headache and vomiting.

~~For other possible undesirable reactions, and precautions,~~
please see summary of prescribing information on opposite page.

*Koch-Weser, J., et al.: *Arch Intern Med*, 128:399, 1971

For nonobstructed cystitis

begin with

Gantrisin[®]
sulfisoxazole/Roche[®]

Usual adult dosage:

4 to 8 tablets *stat*
2 to 4 tablets *q.i.d.*



What it means to live and work in Tipton County, Tennessee

**Persons who are white and
over 40 have one chance in four
of having solar keratoses...
which may be premalignant**

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons
over 40 in Tipton County, Tennessee**

Female	159	44
Male	117	66

☐ Persons without solar keratoses ☒ Persons with solar keratoses

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

5% cream—a Roche exclusive

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

an alternative to conventional therapy **Efudex[®]** (fluorouracil) cream/solution



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



Though environmentalists and some state officials have doubts about the proposed air pollution control implementation plan, **Henri Minette**, deputy director of the Health Dept. defended it as "one all of us can live with and one we can enforce. . . . The plan is a heck of a lot better than anything we've had before. And equally important is the fact that, although they don't like it as well as we do, industry can live with it too." But on the other hand, **Leigh Sakamaki**, chairman of HMA's Environmental Health Committee disagrees. Leigh feels that "the intent of the bill may not be to effectively enforce antipollution laws. . . . Statutes, rules and regulations are meaningless unless they are both enforced and enforceable. . . . We feel the bill lacks teeth in both regards." (Someone defined environmental pollution as "domain poisoning.")

Kauai's **Patrick Cockett** has been the center of much of the controversy whether to locate the Kauai Community College at the Wailua River Site or at Puhi. He has resigned as a UH Regent and said, "My term was up on Dec. 31 and I have told the Governor no-no."

"5 Doctors Against H-3." **Leigh Sakamaki**, **Felix Lafferty**, **Ray Dusendschon**, **Charles Judd**, and **Arthur Nielson** came out with a joint statement against the proposed H-3 Freeway. They wrote, "Automobiles in fact are the largest continuous source of pollutants in metropolitan Honolulu. Thus, any logical environmental impact planning would have as one of its components the reduction in the number of autos, directly leading to a reduction in our air pollutants. Building more free-ways, which in turn encourages more cars on the roads, thus perpetuates a contradictory philosophy to the State's avowed aims to combat pollution and build a healthier environment. The H-3 Environmental Impact Statement in fact does not deal with this basic question, nor does it offer alternatives, such as mass transit lines, to the very real transportation problems we have. People want and deserve better transportation. People also want and deserve a healthy environment. Governmental decisions that don't take both into account shortchange the people. . . ."

It seems Hawaii and Florida are the only states left with residency requirements and the question of residency requirements has been challenged on constitutional grounds in recent years. **Harry Arnold, Jr.** testified at the legislative hearings that the residency requirement "has hampered and continues to hamper the Straub Clinic in obtaining well trained physicians." A **Sam Caldwell** representing the HSP said, "The sugar companies in rural areas have a difficult time attracting doctors because of the law." HMA executive secretary **Tom Thorson**, representing the HMA, supported the present law and said that there are already provisions for allowing an incoming doctor to practice in rural areas if a need is shown. Tom warned that if the requirement is repealed, a doctor could practice for 18 months with a temporary license and no examination. "The Association is concerned with protection of the public against unqualified practitioners."

Medical Daffynitions

Vasectomy: Tying the scorer. **Planned Parenthood Association**: Emission Control Center. **Impotence**: A lack of response-ability. **Phallus**: A member in good standing.

Visiting Physicians

Julius Krevans, Dean of UC at San Francisco spoke at a Queen's Conference on "Blood Component Therapy and Adverse Transfusion Reactions."

- transfusion risks: One should ask the same ques-
- continued page 146*

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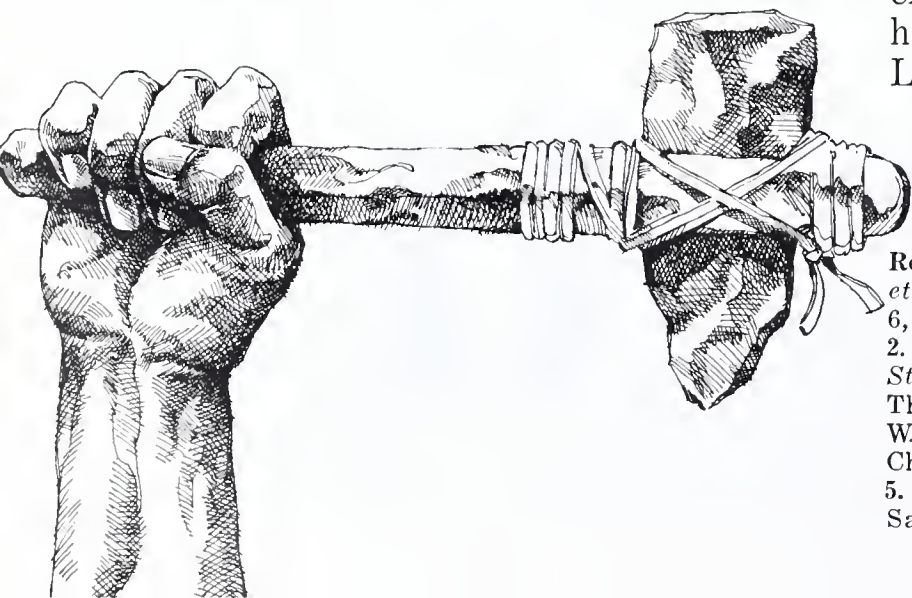
At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are especially vulnerable when their manly assertive independence is threatened.²

Hypersecretion—an atavistic response.

One investigator, who has studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to man's atavistic urge to devour his adversary. It is striking, he reports, that an accentuation of gastric acid secretion and motility can be induced in patients with ulcers by discussions that stimulate feelings of inadequacy, frustration and resentment.²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. He concludes that it may be more than coincidence that peptic ulcer patients appear to be a lean, hungry, competitive group.³



Big boys don't cry. If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. According to another clinician, when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



Take away stress, you can take away symptoms.

There is no question that stress plays a role in the etiology of duodenal ulcer. One prominent physician⁵ has observed that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax®. For most patients, the rest cure is as unrealistic as it is desirable. Still, the excessive anxiety must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M., et al. (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 1444. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.

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Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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they may within thirty days submit their reasons for disagreement in writing to the Society Committee on Peer Review, which shall then determine whether or not an appeal is justified. The Committee Chairman shall so notify the parties involved of its decision by registered mail with return receipt requested. If an appeal is deemed justified, the Chairman shall set a reasonable time and place for such an appeal and notify all parties in writing. Decisions of the Society Committee on Peer Review may then be further appealed to the Hawaii Medical Association Adjudication Committee for final judgment, if necessary.]

NOTE: CHANGES ARE INDICATED BY () WITH ADDITIONS IN [].

The discussion of the proposed changes was led by the eloquent stalwarts of the Society: Drs. Moran, Morris, and Iaconetti, and made lively and interesting by Drs. Dietrich, Haling, Burden, and Peat. Our neophyte president remarkably guided the spirited participation with parliamentary expertise.

The Diabetes Survey of 2,228 people resulted in 17 new diabetics. Gratitude was expressed for the splendid cooperation of the Molokai Lions Club members and Dr. A. Y. Wong was commended for the entire effort.

Dr. Percy, as outgoing chairman of the Utilization Committee, recommended that since Hale Makua had already its own medical staff, it should provide for its own review. This was approved.

Dr. Percy also recommended that Lanai and Kula Hospitals be reviewed by the Maui Memorial Hospital Utilization Review Committee. Drs. Wong and Fu expressed disagreement to this idea during the discussion. No action was taken on the recommendation.

That the Society take over the function of reviewing the utilization of all the institutions in Maui County was

discussed. It was referred to the committee for further study.

Dr. Iaconetti reported briefly on the HMA Council Meeting. He touched on the Legislative Committee's support for legislation on emancipating minors, aged 14 or older, enabling them to sign consent for family planning and pregnancy.

Efforts to regulate Physician's Assistant generated enthusiastic remarks by Drs. Uehara, Moran, and Morris.

In the enforcement of the Phase II of President Nixon's Economic Policy, Dr. Iaconetti recommended that doctors should post notices in their offices to the effect that they are following the RVS 1965, pending use of 1970 fee schedule which is available to any interested party by asking the office receptionist. (Penalty for non-compliance is \$2,000 per day.)

He also recommended continuation of the smallpox vaccinations.

The Treasurer's report was read and approved.

The HMSA letter to the County Society regarding Federal Grant to form HMO's was read. Dr. Morris discussed the letter and cited the Maui experience.

The request of the Maui Pharmacy Society for signatures of Maui physicians to prevent forgeries was approved.

The first Society meeting of the year was very meaty, not only because we had sizzling steaks, but also due to the productive and enlightening discussions of the members catalyzed by the atmosphere of congeniality and camaraderie.

Any physician interested in contributing to a book on the role of faith on religion in healing, from a physician's standpoint, please write: Claude A. Frazier, M.D., 4-C Doctors Park, Asheville, N.C. 28801.

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Slants and Angles continued from 120

willing to recognize how they may have denied a patient help for his real problem in the very act of complying with his overt request for a pill. The near-epidemic extent of amphetamine abuse which exists in this country today is at least in part a result of the medical community's basic willingness to recognize that fulfillment of its first responsibility is not always identical with the most immediate and economic alleviation of pain and suffering.

W. PHILIP JONES, M.D.

Notes and News continued from 140

tion with transfusions as one asks with exploratory surgery. . . . Is this worth the risk?

- transfusion reactions: The incidence is one out of 20. The reactions are classified as mechanical, contamination, hypersensitivity, and immunological incompatibility.

- homologous serum hepatitis: Out of 1000 patients receiving one unit of contaminated blood, one will die, 100 develop hepatitis, and 10 will be jaundiced. The mortality rate after age 40 is 23% compared to 0.9% for those under 40.

Julius says, "If I have created an impression of horror and tragedy, I'm delighted. . . ." Why are we seeing incompatibility reactions. . . . The reason is not failure of technology, but rather human error, eg, wrong label-

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ing, etc. . . . "Transfusions are much safer than in the past, but continue to carry substantial risk. . . . I don't think component therapy is a complex problem. . . . We must convince the physician that transfusions are not a routine kind of therapy. . . ."

Re, the question when to give Dextran, "When the patient loses cells, I give cells, when the patient loses plasma, I give plasma. When the patient loses Dextran, I give Dextran."

In summary, he emphasized, "Transfusion reactions is a problem of the physician and the patient and not that of the blood bank. . . . Fact: one out of 20 have some sort of reaction. . . . Fact: Transfusions have the morbidity and mortality of an exploratory lap."

V. K. Vaitkevicius, a bespectacled, medium statured, brilliant speaker with thinning grey hair and a delightful accent was the Tutor Oncologist in February from Wayne State University. We gleaned the following:

● minimal or borderline colon-recal CA's: I personally would not treat the patient at all. I would be reluctant to use chemotherapy alone. . . . I would feel bad about a trial of potentially harmful drugs. . . . (VK then related the story of a physician who went to a meeting, heard 5-FU proponent **Fred Ansfield**, went home and gave a patient with breast Ca a full dose schedule of 5-FU. The patient died 3 days later sans gastric lining and sans platelets. . . . I am opposed to a protocol with 5-FU alone. . . . 5-FU alone helps less than half the patients. . . .

● adjuvant protocol: In gastrointestinal Ca, any combination treatment with 5-FU is superior to 5 FU-alone. . . . Prednisone and Cytosin have no place in gastrointestinal Ca adjuvant therapy. . . . When you combine zero with zero, you get zero. (VK recommends 5-FU with Mitomycin C.)

● second look operations: Probably with colon Ca, but not with gastric Ca since injury to tissue decreases its ability to fight cancer.

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● colon Ca: Whenever possible the primary tumor should be removed even in palliation. . . . The only patient who should not have the primary removed is the patient dying with metastasis.

Roar Nissen-Meyer, Clinical Endocrinologist from the Radium and Aker Hospital in Oslo, Norway, spoke at Kuakini on "Castration in Breast Ca." We had met Roar earlier and found him to be a quiet, pleasant unassuming, pale man with a fixed smile, and learned that his forte was cross-country skiing. He kept admiring the gaudy aloha shirts we wore and made a mental note to get one. So when he appeared for the lecture several days later, he proudly sported a goodly sun burn and a flower pattern aloha shirt. A hesitant speaker, but nevertheless explicit and understandable, Roar showed that in his series (over 1200 cases) there was a definite increased 5-year survival with irradiation castration and prednisone 2.5 mg qid postop in breast Ca's of Stages I and II. He showed that irradiation castration gave better results than surgical castration. Also his larger series showed a

significantly better overall postop survival than Illinois' **B. J. Kennedy's** results, which seemed to indicate no difference in overall survival whether the castration was done immediately postop or after recurrence of symptoms. . . .

James McKenzie-Pollack, professor of international health at the U of H School of Public Health, likens the American health care system to "a bunch of pushcart vendors in a supermarket society," but feels the system is undergoing a transition. . . . "In the past, medical care was a private contract between the doctor and his patient. But Federal legislation—especially during the last five years—has put a whole new factor into the equation." At present, doctors and medical facilities are concentrated in wealthy and middle-class neighborhoods of large cities. This is a natural product of the free enterprise system. But when a prepaid plan is legislated, the poor and middle class will have the same purchasing power for medicine, because both will be policy holders."

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Moreover, James sees a resurgence of old-time illnesses. "We enjoyed a euphoria in the 1950's during which the world believed that science and technology had all the answers to our economic and even social problems, but we haven't applied our technology. . . . We have to get over our affluent complacency and our idea that we are invincible to disease for the bell will toll for us all, if the deterioration of world health is not checked. . . ."

Willard Gaylin, professor of psychiatry with Columbia Med School, says, "The time for private medicine has passed." Willard questions the ethics of the medical profession in contemporary society where "health is a right rather than a purchaseable commodity. . . . We don't sell seats in lifeboats, and similarly, medical services should not depend on people's financial ability. . . . "Society will soon have to come to grips with the matter of priorities. . . . The question of who should decide in the future about giving 'smart pills' to children (whether only retarded children or also those who are genetically entitled), who should be in control of decision making

about genetic copying, and how the decision is to be made about who should live and who should die (eg, with the advent of heart, kidney transplants and new drugs) and which research should have priority within the available funds for medicine. . . ."

Physicians Speak Up

Plastic surgeon Robert Swaim Flowers who averages 200 per year, says, "Breast augmentations are simple and common." "Surgery can be done in the office at a rate of two a day. . . . The girl who wants a breast implant is tired of being deprived of the badge of femininity." Bob also did 25 breast reductions last year. He sees a good bustline in terms of an isosceles triangle with the nipple located one third of the way up from the inframammary fold, but he is not pleased with the forecast of more breast reductions. Aesthetic Bob says, "I'm very reluctant to take a young, unscarred breast and put scars

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in it. My patients are pleased, but they have to know what to expect. . . . With fear and trembling, I do the operation and try to create a happy patient."

When controversial columnist **Rev. Larry Jones** had to discontinue his column for the Advertiser, **Shig Horio** wrote, "It's not quite clear to me why you are asking Larry Jones to discontinue his column, but I think it is a great loss. We can all improve living our religious principles. When sensitive Christians like Larry or **Del Rayson** or **Jim Douglass** despair of the establishment, it behooves us to listen and consider carefully their prophetic views. Please do not still his voice."

Berk vs Chesne

(To diet or not to diet)

While **Mort Berk**, former president of the Hawaii Heart Association, strongly advocates diet control, incumbent president **Ed Chesne** poohpoohs the idea. Ed

says, "The implication that a high cholesterol level causes heart disease bothers me. It's just a statistical correlation and nobody has proved it. High blood pressure, high cholesterol, obesity, diabetes, and smoking are not called 'causes' of heart disease any more. . . . They are not 'causes', but 'risk factors.'" Mort agrees in principle, but is convinced that a restricted diet could lower one's chances of having heart disease. "The diet is very important from the standpoint that high blood cholesterol is supposedly the best indication of picking out a person who will have a coronary in the future. It is not alone the only thing, but it is the single most important one. The classical profile of a future heart patient is one with high cholesterol, high triglycerides, and high blood pressure; one who smokes, does little or no exercise, and has a family history of heart attacks or diseases of the circulatory system, and diabetes." Mort maintains that a person can't change inherited problems such as blood pressure, strokes, and diabetes, but he can stop smoking (Perhaps a dig at Ed, who chain smokes),

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drop the food intake, and cut down on fatty foods. Besides, diabetes and high blood pressure can be treated medically. As to exercise, Mort deplures people who play golf once or twice a week and say they've gotten some exercise. "Our aim is to get people's hearts to beat faster than they do normally. The heart's a muscle, like any other, and needs to be exercised. The exercise you get playing golf is not really worthwhile." Ed, on the other hand, says, "The effect on the blood pattern of fatty substances by a rigorous pursuit of a fat free diet is not a great one. More than half the patients in the coronary care unit have normal blood fats and triglyceride counts and they still develop coronary disease. A third and important point is that there are drugs available which have an effect on the blood fats and the individual does not have to go on any special diet." (Osler: *We are all dietetic sinners; only a small percent of what we eat nourishes us, the balance goes to waste and loss of energy.*)

"What does the new sexual freedom mean? Why is

it happening in this 3rd quarter of the 20th century?"

Milton Diamond, professor of anatomy at the U of H Med School, views sex as a natural body function. "Whether what is happening is healthy or unhealthy depends upon the value system. Its like saying, is it better to be tall or short? Obviously in some cultures such as Scandinavia, Holland, Germany, where prostitution is legal, it is regarded as a normal sanctioned activity. With us it is open but still illegal. What's wrong with being sexual? We are all sexual human beings. English poets wrote about the beauty of love on the grass and Shakespeare wrote about Romeo and Juliet. Remember, they were only 13 or 14 years old. . . . No one discovered sex in 1971. The Hawaiians fit it into their society as part of the body function. They enjoyed it. A king could walk down the street and pick up a girl if he wanted to and it was an honor for her to be chosen. . . . It was the missionaries who were uptight about sex. They brought out the muumuu. I ask you, 'Who had the dirty

continued page 154

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the pain

the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, anger, and frustration. It's very likely that these psychic factors actually accentuated his perception of pain. Surely the last thing he needs is an analgesic containing caffeine. A much more logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?


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Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital ($\frac{1}{4}$ gr.), 16.2 mg. (warning: may be habit forming); Aspirin ($2\frac{1}{2}$ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

 Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on prescription and may be refilled 5 times within 6 months, unless restricted by state law.



Snifter working again

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

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**Dimetapp
Extentabs®**

Dimetane® (brompheniramine maleate), 12 mg; phenylephrine HCl, 15 mg; phenylpropanolamine HCl, 15 mg

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: Use in children: In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

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mind?" "I think our values are changing, not only in sex, in everything. Our values are changing toward religion, government, big business. We're beginning to question everything. . . . The old values didn't work. The size of the world has changed, conditions have changed. We need to re-evaluate. But one of the dangers of re-evaluation is that you may throw away some of the good values."

Physicians Speak Up

Now that relations with mainland China have been reestablished, many China experts including our **Richard You** (a Korean-Hawaiian of all things) points that besides pingpong, China has athletes starring in volleyball, running, weight-lifting, track and field, soccer, tennis and basketball. "There was **C. K. Yang**, a world class pole vaulter at UCLA, who later won the national decathlon championship. There was Miss Chi Cheng, the world's fastest woman, who holds most of the international sprint records. One of the great pro golfers in the world is Chen Chin Po who is now a club pro in Japan and recently won the Japanese Open crown. Not long ago the Chinese claimed that one of their athletes had set world record in the high jump, clearing something like seven and one-half feet. The mainland Chinese are internationally famous for their table tennis. They have kung fu, a Chinese type of karate and they have good distance runners. They have some very fine weight lifters too."

Regarding legalization of marijuana, **Bob Fisher** says, "I'm inclined to be pro-legalization. Not because I think it is a great drug, but to take it off the black market, for one thing. And because prohibition has taught us that laws don't stop people from using a drug. It just tends to encourage law breaking."

Announcements

32ND ANNUAL AMA CONGRESS ON OCCUPATIONAL HEALTH

The 32nd Annual AMA Congress on Occupational Health will be held at The Drake Hotel in Chicago, September 11-12, 1972. For additional information, write: Henry F. Howe, M.D., Secretary, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

POSTGRADUATE COURSE: ADVANCES IN CLINICAL GASTROENTEROLOGY

Presented by the American College of Physicians, June 8-10, 1972 at Yale University School of Medicine, New Haven, Connecticut. For registration, information, and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

THREE DAYS OF CARDIOLOGY

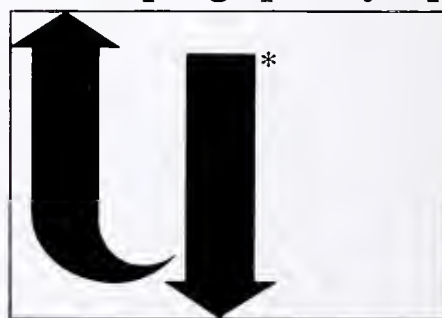
Presented by the American Heart Association, Council on Clinical Cardiology and the American College of Physicians. To be held May 17-19 at Georgetown University, Washington, D.C., the program is entitled "The Physical Examination of the Cardiovascular System—1972." For registration, information and application, write: Mrs. Gail Magzamen, American Heart Association, 44 East 23rd Street, New York, New York 10010.

SYMPOSIUM—COMMUNITY EMERGENCY MEDICAL SERVICES

To be held at the Astroworld Hotel, Houston, Texas, May 26-27, 1972. Co-sponsored by the American Medical Association and the Harris County Medical Society. For additional information write: Harris County Medical Society, 400 Jesse H. Jones Library Bldg., Texas Medical Center, Houston, Texas 77025.

continued page 156

Keeping quality up



and cost down

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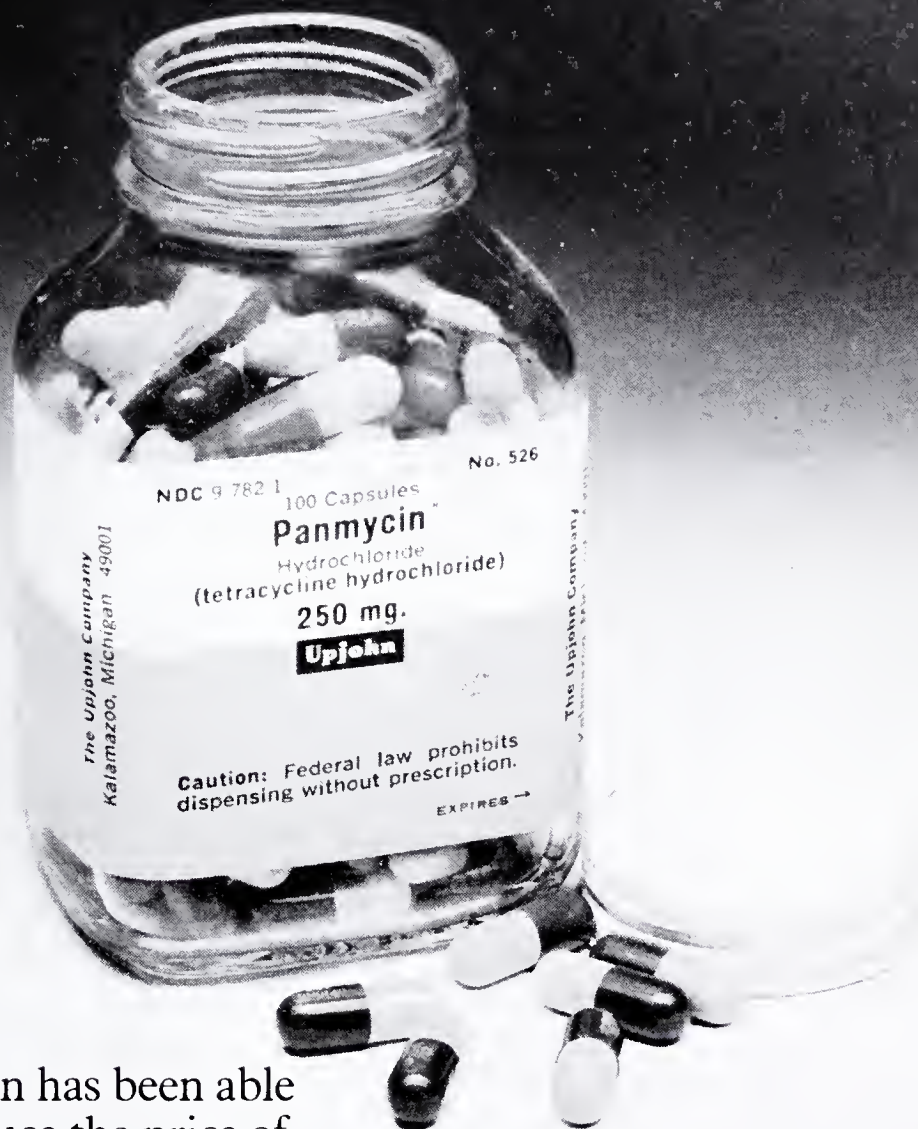
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MECHANISMS**

Presented by the American College of Physicians, June 5-7, 1972 at the University of Iowa, Iowa City, Iowa. For registration, information and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**POSTGRADUATE COURSE: MANAGEMENT OF
COMMON CHRONIC MEDICAL DISEASES**

Presented by the American College of Physicians, May 22-26, 1972 at the University of Kentucky, Lexington, Kentucky. For registration, information and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**POSTGRADUATE COURSES: PROGRESS
IN NEPHROLOGY**

Presented by the American College of Physicians, May 24-26, 1972 at Georgetown University Hospital, Washington, D.C. For registration, information and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

**AMERICAN THORACIC SOCIETY,
1972 ANNUAL MEETING**

A postgraduate program entitled "Interstitial and Vascular Disease of the Lung" will highlight the meeting scheduled for May 21-24, 1972 in Kansas City, Mo. For registration, information and application, write: Jesse Rising, M.D., Dept. of Postgraduate Medicine, University of Kansas School of Medicine, 39th Street at Rainbow Blvd., Kansas City, Kansas 66103.

**EIGHTH INTERNATIONAL CONGRESS
OF ELECTROENCEPHALOGRAPHY AND
CLINICAL NEUROPHYSIOLOGY**

To be held in Marseille, France, September 1-7, 1973. The emphasis of the Congress will be on Free Communications. Papers will be selected on the basis of originality and quality. There will also be two EEG Round Tables ("Possibilities and Limitations of New Methods of Data Collection and Analysis"; "Basic Mechanisms of Epilepsy"), two EMG Round Tables ("Computer Analysis of the EMG" and "Histopathology of Nerve and Electrophysiological Correlations") and a Common Session in the "Clinical Neurophysiology of Speech" (including mechanisms of reading and writing). There will also be a concurrent program of didactic lectures and demonstrations (for senior technicians, technologists and clinicians), scientific exhibits and demonstrations, commercial exhibits. The official languages will be French and English. There will be a banquet at the Palace of the Popes at AVIGNON. Inquiries may be directed to the Secretary of the Congress, Mme. le Dr. G. C. LAIRY, Hôpital Henri Rousselle, 1, rue Cabanis, Paris 14°, France.

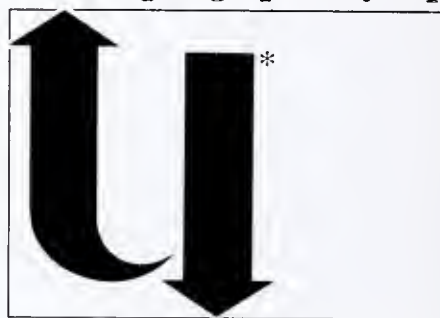
SEVENTH NATIONAL CANCER CONFERENCE

Sponsored by the American Cancer Society and the National Cancer Institute, September 27-29, 1972 at the Biltmore Hotel, Los Angeles, California. For registration and information write: Sidney L. Arje, M.D., Coordinator, Seventh National Cancer Conference, c/o American Cancer Society, Inc., 219 East 42nd Street, New York, N. Y. 10017.

**NATIONAL CONFERENCE ON HUMAN
VALUES & CANCER**

Sponsored by the American Cancer Society, June 22-24, 1972. Regency Hyatt House, Atlanta, Georgia. For registration and information write: William M. Markel, M.D., National Conference on Human Values & Cancer, c/o American Cancer Society, Inc., 219 East 42nd Street, New York, N. Y. 10017.

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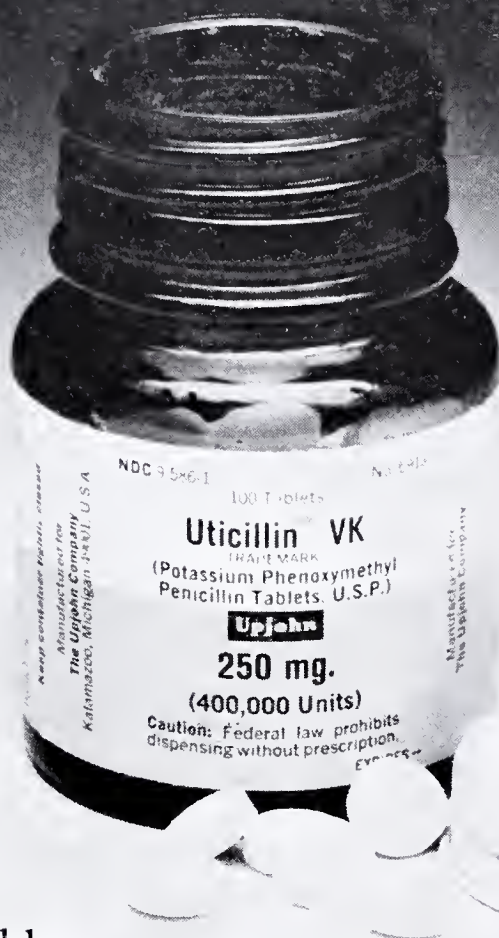
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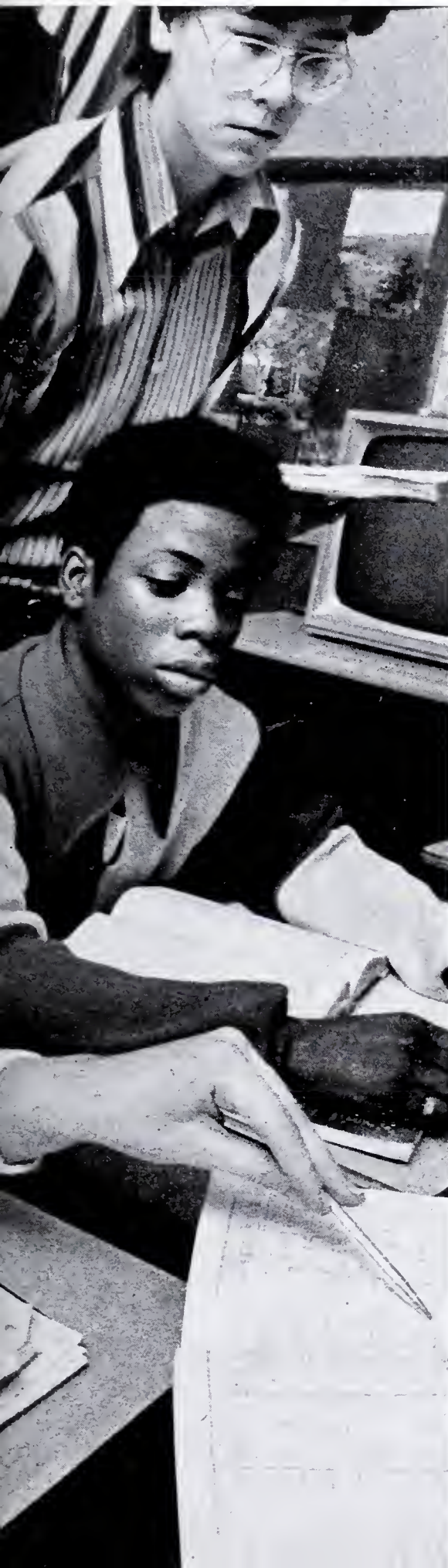


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...and now who would know she's an epileptic



When your anticonvulsant regimen only partially controls epileptic symptoms, the concomitant use of MYSOLINE (primidone) in appropriate cases may help you achieve your ultimate therapeutic objective—to bring patients back to normal patterns of living.

The use of MYSOLINE to control seizures when other agents have failed is often possible. Its value in grand mal and focal seizures is well recognized. Furthermore, MYSOLINE has been described as an excellent drug in the treatment of psychomotor seizures.*

Early side effects with MYSOLINE such as ataxia and vertigo are usually transient, and tend to disappear with continued therapy or dosage reduction. MYSOLINE, used either alone or added to other agents, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. Consider it for epileptics in your practice . . . to help them lead *normal* lives.

*Millichap, J.G.: Drug therapy and management of the child with epilepsy, *Drug Therapy* 1:15 (Oct.) 1971.

MYSOLINE® (primidone) used alone...used with others... used when others fail

BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE (primidone) Anticonvulsant

INDICATIONS: MYSOLINE, either alone or in combination, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, routine laboratory tests are indicated at regular intervals.

Use in pregnancy: The effect of primidone on the human fetus has not been studied, and the benefit of administration of any drug during pregnancy must be weighed against any possible effect on the fetus.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking MYSOLINE and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

In nursing mothers: There is evidence that in mothers treated with MYSOLINE, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE (primidone)-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE (primidone) should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances: for initiation of combination therapy; during "transfer" therapy; for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.).

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 0.25 Gm. (250 mg.) of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 0.25 Gm. (250 mg.) of primidone, in bottles of 8 fluidounces.

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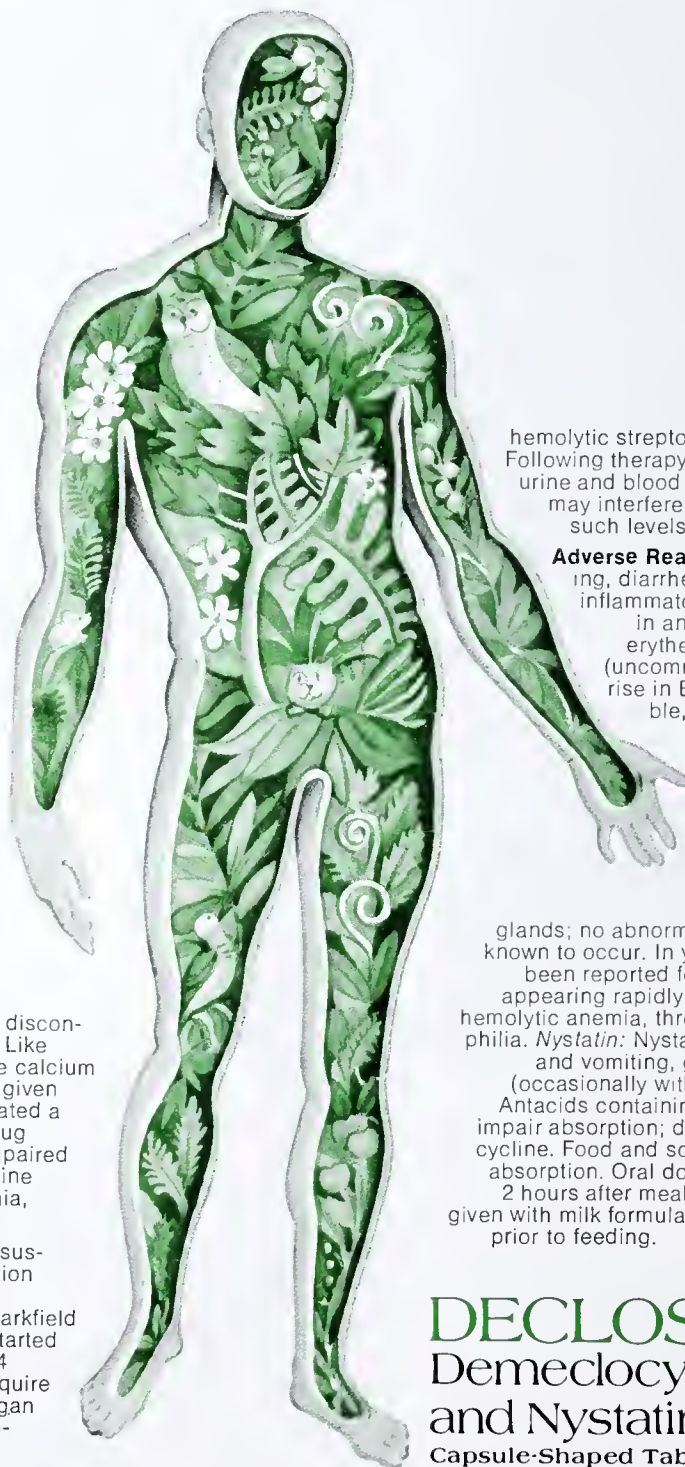
MYSOLINE® (primidone) is available in the United States by arrangement with Imperial Chemical Industries Ltd.

HUMAN ECOLOGY

Human beings are ecosystems, inhabited by populations of microorganisms. When antibiotics alter the balance of these populations in the G.I. tract, monilial overgrowth can ensue.

The Nystatin component of DECLOSTATIN is present to help control such overgrowth.

DECLOSTATIN is particularly relevant for treatment of bacterial infection caused by sensitive organisms in such monilia susceptible patients as diabetics, the elderly or debilitated, and others with a history of moniliasis.



Actions: Tetracyclines are active against a wide range of gram-negative and gram-positive organisms. Nystatin is an antifungal agent against *Candida* (monilia) *albicans*.

Contraindications: Hypersensitivity to any tetracycline or nystatin.

Warnings: The Use of Drugs of the Tetracycline Class During Tooth Development (Last Half of Pregnancy, Infancy and Childhood to the Age of 8 Years) May Cause Permanent Discoloration of the Teeth (Yellow-Gray-Brown). This Adverse Reaction is More Common During Long-Term Use of the Drugs But Has Been Observed Following Repeated Short-Term Courses. Enamel Hypoplasia Has Also Been Reported. *Tetracycline Drugs, Therefore, Should Not be Used in This Age Group Unless Other Drugs Are Not Likely To be Effective or Are Contraindicated.* In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower doses, and, in prolonged therapy, determine serum levels. Phototoxic reactions, characterized by severe burns of exposed surfaces, can result from direct exposure to sunlight during therapy with moderate to large doses of demeclocycline. Advise patient of this reaction to sunlight or ultraviolet light, and discontinue treatment at first evidence of skin erythema. Like other tetracyclines, demeclocycline forms a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least 4 months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta

hemolytic streptococcal infections for at least 10 days. Following therapy, persistence for several days in both urine and blood of bacteriosuppressive levels of drug may interfere with culture studies. Do not consider such levels as therapeutic.

Adverse Reactions: *G.I.:* anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity. *Renal toxicity:* rise in BUN, dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given over prolonged periods, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *Nystatin:* Nystatin has been associated with nausea and vomiting, gastrointestinal distress and diarrhea (occasionally with large doses). *Concomitant therapy:* Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patient taking oral tetracycline. Food and some dairy products also interfere with absorption. Oral doses should be given 1 hour before or 2 hours after meals. Pediatric oral doses should not be given with milk formulas, but should be given at least 1 hour prior to feeding.

DECLOSTATIN® 300
Demeclocycline HCl 300mg
and Nystatin 500,000 Units
Capsule-Shaped Tablets Lederle

MAY / JUNE 1972

HAWAII MEDICAL JOURNAL

VOLUME 31 / NUMBER 3



IF MORE MEN CRIED



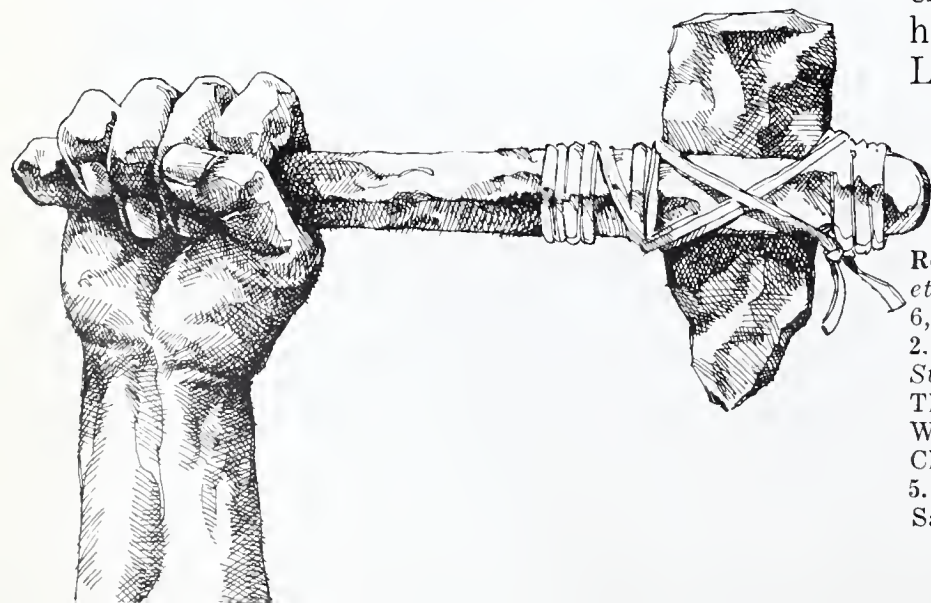
At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are especially vulnerable when their manly assertive independence is threatened.²

Hypersecretion—an atavistic response.

One investigator, who has studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to man's atavistic urge to devour his adversary. It is striking, he reports, that an accentuation of gastric acid secretion and motility can be induced in patients with ulcers by discussions that stimulate feelings of inadequacy, frustration and resentment.²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. He concludes that it may be more than coincidence that peptic ulcer patients appear to be a lean, hungry, competitive group.³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. According to another clinician, when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism. Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



Take away stress, you can take away symptoms

There is no question that stress plays a role in the etiology of duodenal ulcer. One prominent physician⁵ has observed that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax®. For most patients, the rest cure is as unrealistic as it is desirable. Still, the excessive anxiety must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that

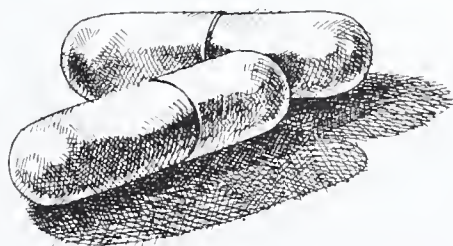
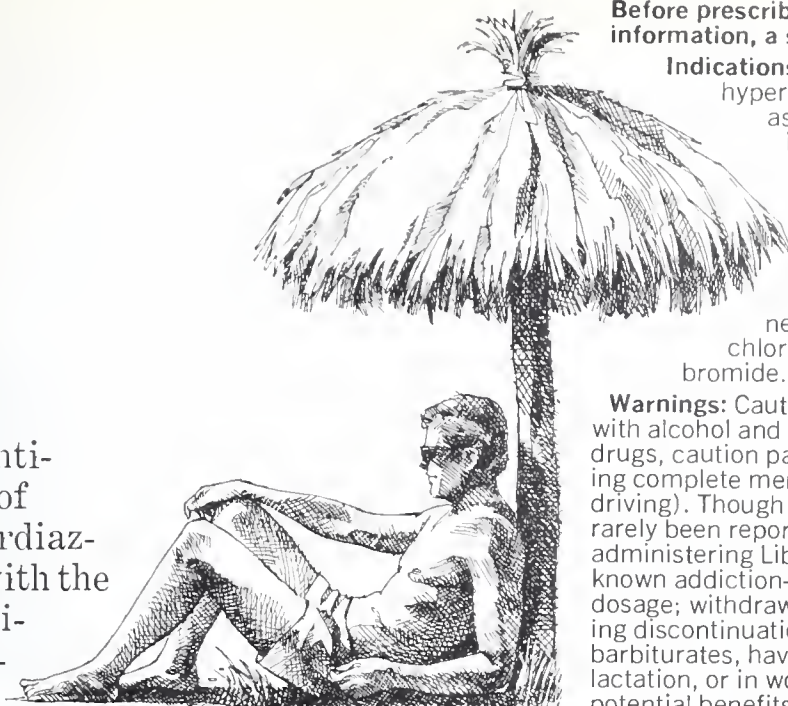
References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M. et al. (eds.): *Harrison's Principles of Internal Medicine*, 6th ed., New York, McGraw-Hill Book Company, 1970, p. 144. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff: Stress and Disease*, ed. 2, Springfield, Ill., Charles C. Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 16. 5. Alvarez, W. C.: *The Neuroscs*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.

ombines the anti-anxiety action of Librium® (chlordiazepoxide HCl) with the dependable anti-secretory/anti-spasmodic action of Quarzan® (clidinium Br).

Protects man from his own hungry personality. The action of Librium helps reduce excessive anxiety and thus helps protect the vulnerable patient from this type of overreaction to stress. At the same time, the action of Quarzan helps quiet the hyperactive gut, decreasing hypermotility and hypersecretion.

An inner healing environment with 1 or 2 capsules, 3 or 4 times daily. Of course, there's more to the treatment of duodenal ulcer than a prescription for Librax. The patient—with your guidance—will have to adjust to a different pattern of living if treatment is to succeed. During this adjustment period, 1 or 2 capsules of Librax 3 or 4 times daily can help establish a desirable environment for healing.

Librax: It can't change man's nature. But it can usually make it easier for men to cope with the discomfort of stress—both psychic and gastric—that can precipitate and exacerbate the symptoms of duodenal ulcer.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

in the treatment of
duodenal ulcer
adjunctive
Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

When your diagnosis is seborrheic dermatitis of the scalp, the classic drug for controlling scaling and itching is Selsun[®] (SELENIUM SULFIDE LOTION)

Precautions and side effects: Keep out of the eyes, burning or irritation may result. Avoid application to inflamed scalp or open lesions. Occasional sensitization may occur. Rinse well.

Contains: Selenium sulfide, 2½%, w/v in aqueous suspension: also contains: bentonite, alkyl aryl sulfonate, sodium phosphate, glyceryl monoricinoleate, citric acid and perfume.



Proven
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that only
you can
give.



HAWAII MEDICAL JOURNAL

VOLUME 31, NUMBER 3

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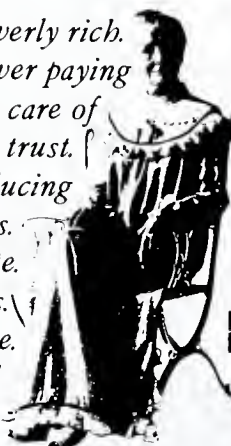
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ANY
LADY WHO CAN
OUTLIVE TWO HUSBANDS
AND SURVIVE
FOUR ROARING SONS,
DESERVES
A GOOD NIGHT'S
SLEEP.

*She's not overly rich.
But she isn't losing any sleep over paying
the bills either. Husband No. 2 took care of
that when he started the trust.
We managed his income-producing
assets and reinvested the profits.
Later, none of it went through probate.
Or down the drain in needless estate taxes.
Instead, the trust sent four sons to college.
And enabled a lady who's seen it all
to keep it all.*



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HAWAII MEDICAL JOURNAL

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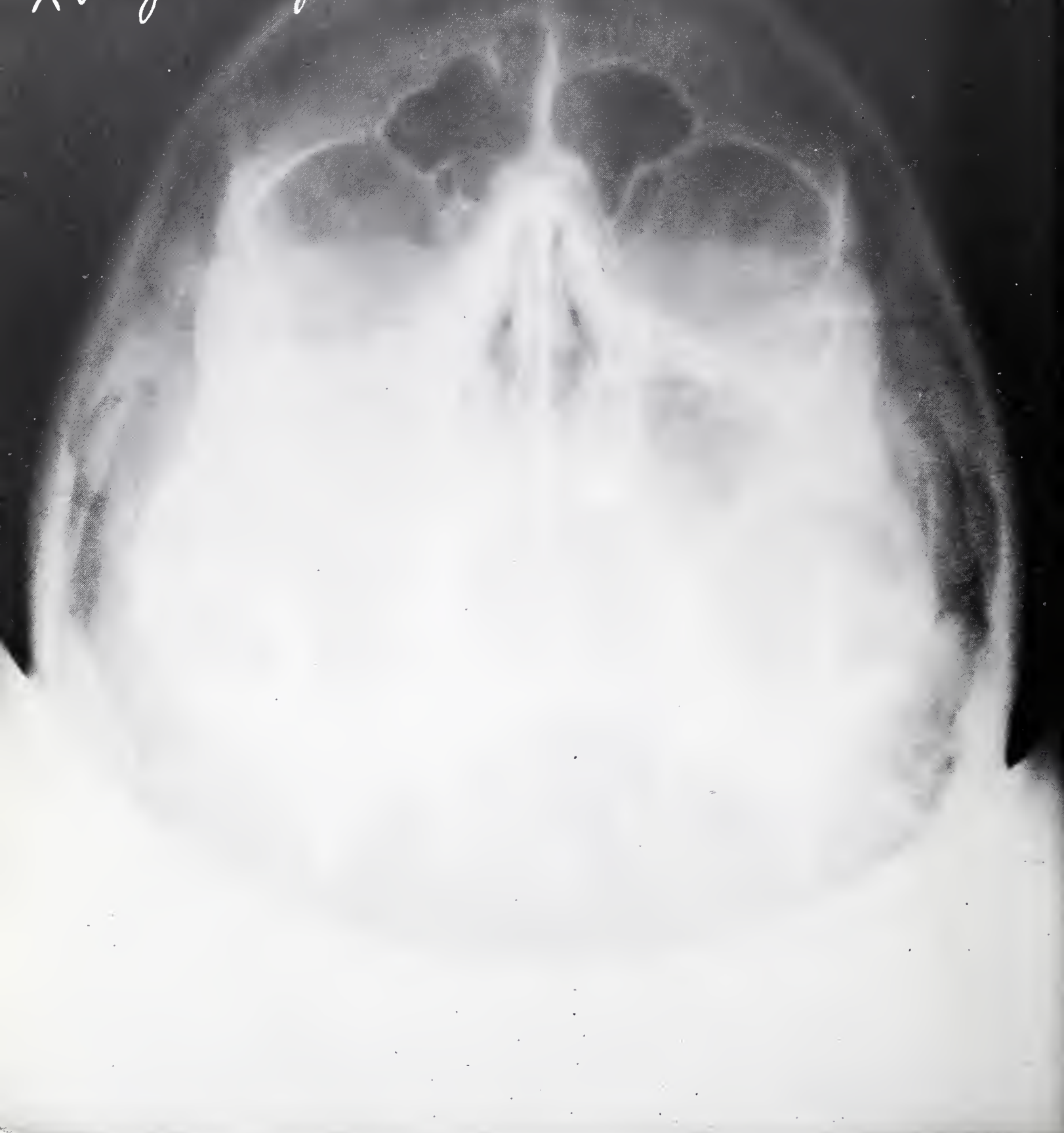
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Cover: From the collection of Meryl H. Haber, M.D. An original print from an engraving by W. Hogarth captioned "The Innkeeper's Wife and Daughter taking care of Don after being beaten and bruised."

CC: Pain on Rt. side of face

Dx: Acute purulent bacterial Max. Sinusitis

X-Ray Interp: Waters - Clouding of Rt. Max. Sinus



There are many frustrations in treating acute sinusitis.

Cleocin manages most of the bacterial ones.

Inadequate drainage, chronic rhinitis, allergy, exposure to temperature extremes, and other factors can delay recovery from acute sinusitis.

It's helpful to have an antibiotic like Cleocin HCl (clindamycin HCl hydrate, Upjohn) that can take care of most of the gram-positive bacterial problems related to the disease.

As one study* of 52 outpatients showed, acute maxillary sinusitis was associated with staphylococci in 50% of the group, with pneumococci in 25%, and with streptococci and various other organisms (chiefly gram-negative) in the remainder. Significantly, one-half of these staphylococcal infections were resistant to both penicillin and tetracycline (all were sensitive to erythromycin and chloramphenicol). Although not a part of this study, many other clinical and bacteriologic reports¹ have shown that such gram-positive bacteria, which most often are associated with acute sinusitis, are usually susceptible to Cleocin.

Can be taken before, with, or after meals

The total absorption of Cleocin is virtually unaffected by the presence of food in the GI tract.¹ Cleocin thus can be administered as prescribed without interfering with the patient's mealtimes.

Useful in patients hypersensitive to penicillin

Cleocin's chemical structure bears no relationship to penicillin or the cephalosporins. Cleocin therefore may be especially useful in patients with acute sinusitis who report a history of hypersensitivity to these antibiotics. Although hypersensitivity reactions have been uncommon with Cleocin, it should be used cautiously in atopic individuals. Cleocin is not recommended in the lincomycin-sensitive patient.

Please see following page for further prescribing information.



© 150 mg capsules

Cleocin HCl

clindamycin HCl hydrate, Upjohn

Side effects: In studies of 1,416 patients involving 92 clinical investigators, side effects were reported in 8.2%.¹ Diarrhea or loose stools were noted in 3% of these cases (one patient with bloody stools). In a few instances, diarrhea lasted several days. A slightly higher incidence of diarrhea or loose stools has been reported by some investigators in subsequent studies.



Toxicity: No irreversible hematologic, renal, dermatologic, or neurologic abnormalities have been reported.¹ Transient leukopenia and eosinophilia have been observed. Elevations of alkaline phosphatase and serum transaminases were observed in a few instances. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

In acute sinusitis and other upper respiratory infections due to susceptible staphylococci, streptococci, and pneumococci.

Cleocin[®] HCl

clindamycin HCl hydrate, Upjohn

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin, Upjohn) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Cleocin HCl (clindamycin HCl hydrate) is indicated in infections of the upper and lower respiratory tract, skin and soft tissue, and, adjunctively, dental infections caused by gram-positive organisms which are susceptible to its action, particularly streptococci, pneumococci and staphylococci.

As with all antibiotics, *in vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: Patients previously found to be hypersensitive to this compound or to lincomycin.

WARNINGS: Safety for use in pregnancy not established. Not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. Perform periodic liver function tests and blood counts during prolonged therapy. The serum half-life in patients with markedly reduced renal function is approximately twice that in normal patients; hemodialysis and peritoneal dialysis do not effectively remove Cleocin from the blood. Therefore, with severe renal insufficiency, determine serum levels of clindamycin periodically and decrease the dose appropriately. Should overgrowth of nonsusceptible organisms—particularly yeasts—occur, take appropriate clinically indicated measures.

ADVERSE REACTIONS: Generally well tolerated in clinical efficacy studies. Side effects reported in 8.2% of 1,416 patients. Of the total, 6.9% reported gastrointestinal side effects and 1.3% reported other side effects. Diarrhea or loose stools were reported in 3%. *Gastrointestinal:* Symptoms

included abdominal pain, nausea, vomiting and diarrhea or loose stools. In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. *Hematopoietic:* Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. *Skin and Mucous Membranes:* Skin rash and urticaria have been reported infrequently. *Hypersensitivity Reactions:* A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. *Liver:* Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections—150 to 300 mg every 6 hours. Severe infections—300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections—8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections—16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β -hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

SUPPLIED: 150 mg Capsules—Bottles of 16's and 100's. 75 mg Capsules—Bottles of 16's and 100's. *Sensitivity Disks*—2 μ g. *Sensitivity Powder*—Vials. For additional product information, see your Upjohn representative or consult package insert. MED B-4-S (LNU-3) JA71-1565

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what grade diabetic retinopathy?*

In diabetes
when nutritional
supplementation
is indicated

Berocca[®] tablets
is therapy

With balanced, high potency
B-complex and C vitamins.
No odor.
Virtually no aftertaste.
Lowest priced Rx formula.

Please see Complete Prescribing Information, a summary of which follows:

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B₁₂.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

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* Grade II diabetic retinopathy is revealed by the small hemorrhages and exudates in this photograph of the fundus.

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**if skin is infected,
or open to infection...
choose the topicals
that give your patient—**

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin[®] Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin[®] brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin[®]-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin[®] brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

A CASE FOR "500"



BRIEF SUMMARY

(For full prescribing information, see package circular.)

GRISACTIN® [griseofulvin (microsize)]

Indications: Griseofulvin is indicated for the treatment of ringworm infections of the skin, hair, and nails, namely: *Tinea corporis*, *Tinea pedis*, *Tinea cruris*, *Tinea barbae*, *Tinea capitis*, *Tinea unguium* (onychomycosis) when caused by one or more of the following genera of fungi: *Trichophyton rubrum*, *T. tonsurans*, *T. mentagrophytes*, *T. interdigitalis*, *T. verrucosum*, *T. megnini*, *T. gallinae*, *T. crateriform*, *T. sulphureum*, *T. schoenleini*, *Microsporum audouini*, *M. canis*, *M. gypseum*, *Epidermophyton floccosum*.

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following: Bacterial infections, candidiasis (moniliasis), histoplasmosis, actinomycosis, sporotrichosis, chromoblastomycosis, coccidioidomycosis, North American blastomycosis, cryptococcosis (torulosis), *tinea versicolor*, nocardiosis.

Contraindications: This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of hypersensitivity to griseofulvin.

Warnings: *Prophylactic Usage*—Safety and efficacy of griseofulvin for prophylaxis of fungal infections has not been established.

Animal Toxicology—Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally ad-

ministered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy—The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies—It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this. **Precautions:** Patients on prolonged therapy with any potent medication should

GRISACTIN[®] 500 Tablets

Brand of
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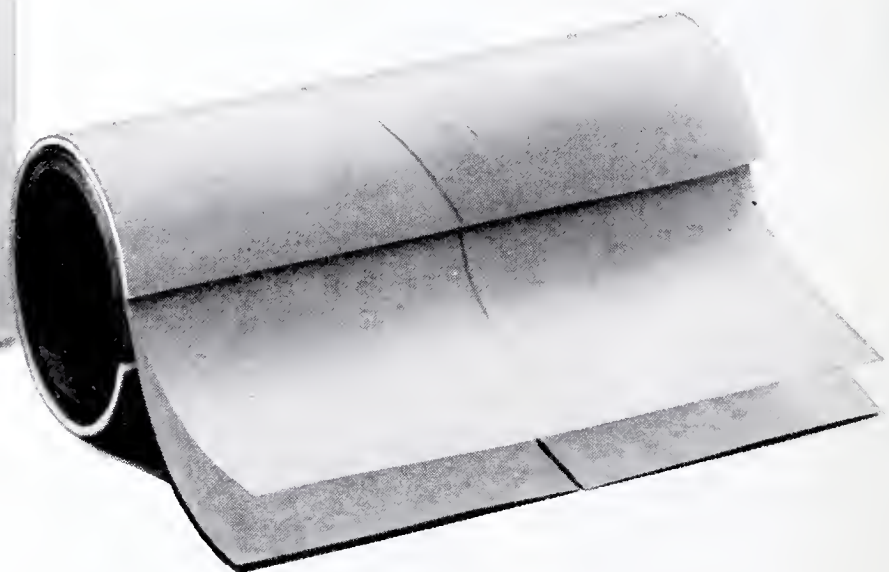
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Team Care—Progress Through Partnership

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With changes in methods of financing of medical care has come a decrease in the number of patients available to educate physicians-in-training by traditional methods. A system of bringing patients of private physicians into the teaching program—the team care concept—has been evolving within the Department of Medicine at St. Francis Hospital. The primary members of the team include the intern, the medical resident, the patient's private physician, and an educator, the teaching attending physician. To enter a patient on team care, that patient's private physician must be willing to allow the other members of the team to actively participate in the management of the patient, and he must agree to abide by the current team care guidelines.

Since its inception in 1967, team care has evolved in three major directions: increasing involvement in programs of undergraduate and graduate medical education for physicians-in-training; effective delivery of optimal levels of medical care to all segments of the community served by the hospital; development of an approach to maintain clinical competence for the private physician. Major incentives for private physicians admitting patients to the medicine service encourage voluntary participation, upon which successful implementation of team care depends.

Based on PAS-MAP data compiled from every medical patient discharged during calendar year 1970, this study suggests that these goals can be substantially approached without compromising

the quality of care, delivery or utilization among team care (70% of total discharges) when compared with private (24%) patients.

The team care concept can serve as a realistic basis on which teaching services utilizing private patients can be further developed. We feel we have designed a rational functioning model to facilitate this crucial step, and believe that broader systems of educational and delivery mechanisms can be evolved from these principles.

IN 1970 a study, commissioned by the Sixth Hawaii State Legislature to assess the state of readiness of the University of Hawaii to expand the two-year School of Medicine into a degree-granting institution, was published by Dr. Walsh McDermott and his associates.¹ This report charged the University to negotiate with existing Honolulu community hospitals to make available 300 or more beds for teaching purposes (necessarily including beds occupied by patients admitted by private physicians), rather than to establish a separate university hospital. Thus, the major expenses of building a university teaching hospital would be avoided. This is in keeping with the Nixon administration policy of avoiding the costs and disadvantages of new teaching hospital construction, while also deemphasizing categorical approaches to solutions of this nation's health problems.^{2, 3}

Success of this experiment, in which an educational institution engages with community resources in a completely interdependent relationship, can have far reaching national implications.

From the Departments of Medicine and Medical Records, St. Francis Hospital.

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St. Francis Hospital has been invited to participate in this exciting and challenging partnership. This paper outlines the philosophies and mechanics of our educational programs and proposes a feasible method to conduct medical education using hospitalized patients of all private community physicians. Concomitant features which enhance medical care delivery while simultaneously promoting the maintenance of professional competence of these community physicians are considered in depth. We propose that systems based upon our strategy can facilitate the realization of this partnership.

Traditionally, clinical teaching of undergraduate and graduate physicians-in-training has been conducted by caring for patients who had no private physicians. These patients fell predominantly into a socio-economic category known as indigent, staff, or non-private patients. Opportunities for trainees to assume primary patient responsibility for the care of these patients under the direct supervision and guidance of a teaching attending physician had been readily available under those circumstances. This was vital for the proper learning experience of the physicians-in-training.^{4, 5} In the process of fulfilling training program requirements and meeting the educational needs of their students, universities and hospitals delivered health care to a group whose health needs would otherwise remain largely unmet.

ALL THAT IS CHANGED NOW

With the implementation of Titles XVIII and XIX (Medicare and Medicaid) in 1967 and the widening scope of medical insurance coverage and health plans, the numbers of patients without physicians have gradually diminished, and survival of teaching programs structured upon this category of patients has been threatened. This "drying up of the teaching-bed population" has been characterized by Dr. George Mixter, Jr., assistant director of the AMA's Department of Graduate Medical Education, as "today's most pressing problem in medicine."⁶ Other methods of providing patients upon whom clinical experience can be obtained must be developed in order to insure properly trained physicians in the future.

A ready resource of in-patients for teaching purposes are those hospitalized by private physicians, the so-called private patients.^{5, 7} In the United States, these private patients comprise the great majority of individuals admitted to an in-patient status. National figures cited by Kerr White indicate, that of nine individuals hospitalized monthly

for illness at acute care hospitals, only one will be admitted to a university teaching hospital.⁸

THE TEAM

At St. Francis Hospital the "team care" system incorporates into the teaching program; private patients of all community physicians who admit to the medicine service. There are two fundamental differences between our team care team and those usual teams of "teaching units" acknowledged to facilitate graduate medical education in educational institutions⁹—first, we have included a part-time, unsalaried educator, whom we call the teaching attending physician (TAP), as an additional and key member of the team; second, the TAP functions without upsetting the traditional doctor-patient relationship or interfering with the prevailing economic and medicolegal arrangements.

Since its inception in 1967, team care has been the instrument enabling evolution toward: (1) increasing involvement in programs of undergraduate and graduate medical education for physicians-in-training; (2) effective delivery of optimal levels of medical care to all segments of the community served by the hospital; and (3) development of an approach to maintaining clinical competence for the practicing physician.

Respected voices have repeatedly urged universities to assume greater responsibility for providing postgraduate residency experience.¹⁰⁻¹⁶ Cautious response to these recommendations reflects awareness of the magnitude of the attendant problems.¹⁷ To carry this out in community hospital settings represents the toughest part of this challenge.

The team care strategy has developed to facilitate this crucial step of providing patients for clinical teaching in community hospital settings. Team care also contains realistic innovative elements which make it possible to meet simultaneously other pressing educational and health needs. Team care is a rational functional model from which broader educational and delivery systems can evolve.

THE LOGISTICS

St. Francis Hospital (SFH), a non-profit community hospital sponsored by a religious organization, has a 256 bed capacity, of which approximately 110 beds are designated for use by the Department of Medicine. Situated on the main island of Oahu, SFH is one of five civilian acute care general hospitals, with a total bed capacity of 1,200, serving over a half million residents of this 608 square mile island.^{18, 19}

One hundred internists and 150 generalists, as well as 390 other specialists, may potentially admit patients to the 110 medical beds (under the open staffing system found throughout Honolulu, with the exception of the 152 bed Kaiser Foundation Hospital); actually, 100 generalists and 125 internists (including neurologists, psychiatrists and other medical specialists) are listed among the 550 physicians holding staff privileges at SFH.

Of 18 interns and nine medical residents rotating through the four team care wards during the study period, 16 were graduates of U.S. medical schools, while five were Canadian graduates and the remaining six were foreign medical graduates from the Philippines, India, Ireland and Germany. The house staff and attending staff are of comparable competence to the staffs of community hospitals with teaching programs throughout this country.

The study is based on information obtained from PAS-MAP case abstract forms which condensed the medical record of each of the 3,358 patients discharged from the medicine service during the period, January 1, 1970 through December 31, 1970. This data is presented as the Professional Activity Study (PAS), Medical Audit Program (MAP) and Physician Index displays of the Commission on Professional and Hospital Activities (CPHA), a non-profit organization devoted "to increasing the accessibility of information contained in medical records so that it can be used to greater advantage in the improvement of patient care."²⁰

Confirmation of the incidence of recorded rectal and fundusoscopic examinations was accomplished by an audit of 150 consecutive team care and 215 consecutive private service hospital medical records, beginning with the records of March 6 of the study year. This random date was chosen because it was the first date of the 1972 selective service draft lottery. Using the chi square test, a P value of less than 0.10 was considered to represent a significant difference.

Patients admitted to SFH fall into one of three categories: (1) staff, or non-private; (2) private; and, (3) team care.

(1) Staff or non-private: These patients attend the outpatient clinics at SFH for their ambulatory care needs, and their care is wholly or in part financed by the Hawaii State Department of Social Services. These individuals make up what was previously termed the "clinic," "welfare" or "indigent" population. All staff patients are hospitalized on one ward which comprises one of the

four team care teaching units, unless they are in an acute care area such as the coronary care unit or an intensive care unit. Their care is provided by a team care team on which there is no private physician member (*vide infra*).

(2) Private: Designated "non-team care" by their private physicians, these patients upon admission are seen briefly by an intern who enters a short note on the progress record. The private physician is responsible for all aspects of the patient's management and hospital record; however, members of the house staff will respond to calls of an emergency nature. Whenever possible, non-team care patients are placed elsewhere than on teaching wards.

(3) Team Care: Designated as "team care" by their private physicians, these patients are promptly seen by the respective team intern upon admission to a geographic team care teaching unit. To enter a patient on team care, the patient's private physician must be willing to allow the other members of the team to actively participate in the management of the patient, and he must agree to abide by the current team care guidelines. All team care patients are available for teaching rounds and other educational activities such as conferences, student presentations and specialty rounds. The primary members of the team include the private physician who admits the patient, the intern, his medical resident, and an educator, the teaching attending physician (TAP).

After evaluating an admission, the intern will confer with his resident and then contact the private physician in order to plan an initial diagnostic and therapeutic program which is mutually acceptable. The medical resident enters an appropriate note in the progress record after reviewing his intern's assessment.

Any private physician may elect to admit to team care, upon which his patient will be placed on one of the four geographic team care wards of approximately 20 beds each. The other three primary members of each team are assigned as follows, an intern and a TAP each for two months, an assistant resident in internal medicine for a three-month rotation. Other individuals may function as supplementary members of the team, including the chief medical resident, the director of medical education, the chief of service, and consultants, as well as nurses and other allied health personnel.

SHARE OF RESPONSIBILITY

Upon entering a private patient on team care, the private physician agrees to share and delegate

responsibility for management of his patient to the physicians-in-training. He must refrain from sending with the patient to the hospital any orders except those of an emergency nature, though he is encouraged to use the central dictation system for recording his own history and physical examination, diagnostic and therapeutic maneuvers and other pertinent data. He further assumes the obligation to communicate with other house staff team members to discuss aspects of the case, thereby assuring two-way interchange. Evaluation of the team work-up, day-to-day supervision and education, and delegation of commensurate responsibility to house staff team members are part of his duties as the team care patient's private physician, as he retains the traditional patient-doctor relationship with its attendant medico-legal and economic responsibilities and rights. A vital element of this patient-doctor relationship is the physician's obligation to familiarize his patient with appropriate aspects of the team care mechanics. The private physician retains the final decision, should there be any questions or conflicts regarding any aspect of his patient's management. Team care is completely voluntary for the practicing physician, and he reserves the option to remove his patient from team care at any time, should circumstances dictate.

House staff members of the team assume several vital responsibilities considered to have distinct educational value, including examining the hospitalized patient initially and promptly, performing and recording the history and physical examination, writing the admission as well as the subsequent orders after thoughtful, guided consideration of differential diagnosis, management, and costs, and finally preparing a concise discharge summary. These functions, along with daily rounds and suitable progress notes are carried out on only those patients for whom the team has team care responsibility. Team rounds are conducted daily including Sundays and holidays, and daily communication with the private physician is crucial.

THE PRIME EDUCATOR

The teaching attending physician (TAP) is an additional primary team member who serves as an educator for each team. He assumes the primary responsibility for guiding the educational activities of each team, acting under the direction and authority of the director of education and the department chief. Chosen primarily from among internists active in the community or on the medical school faculty, the TAP serves in the capacity of

the familiar "on-service" attending physician in the traditional non-private service, overseeing the day-to-day functioning of the ward and being available for consultation and advice for his intern and resident as well as making regularly scheduled teaching rounds three times weekly with them. These rounds usually consist of an in-depth presentation of one or two cases, with periodic sessions being devoted to consideration of a larger number of patients.

Since three of the four teaching wards are composed exclusively of private patients placed on team care, the TAP is often placed in the position of reviewing the work of his colleagues in practice and making recommendations which are based on his evaluation and judgment of their performance. Selection of cases for presentation is made at the discretion of the house staff. Every patient on the teaching unit may potentially be reviewed by the TAP, as well as by the director of education or by the chief on their respective regular rounds.

Twenty-four of the 44 internists participating on our teaching staff as TAPs are board-certified.

During the years of development of the team care strategy, all TAPs have served without remuneration. The only individual in the entire system to receive compensation besides the bona-fide house staff members was the director of medical education, who filled a half-time position budgeted by the hospital. In 1971 this position became full-time and the present director holds a concurrent academic appointment at the University of Hawaii School of Medicine.

AUTOMATIC TEAM CARE STATUS

Certain adjustments limiting the availability of team care have been adopted to enhance the effectiveness of the team care system. All patients admitted to the acute care specialty units such as the coronary care unit or the intensive care units are automatically placed on a team care status, and they may revert to a non-team care situation upon the patients' leaving the acute care areas, should the private physician so desire or should bed availability dictate. Patients may be transferred into team care status after a period of hospitalization as non-team care under a number of circumstances, as long as the involved parties are agreeable and beds are available. Examples of such instances include interdepartmental transfers, patients transferred into acute care areas, cases of unusual educational value, and patients on whom certain consultations are obtained.

Situations also arise wherein patients are not accepted into team care for various reasons: (1) Since teams are geographically situated and the patient load per team is limited, team beds may not be available despite the willingness of practitioners to participate. (2) If physicians do not abide with the criteria set forth, their patients may be denied team care privileges. (3) There are certain categories of patients which have been declared ineligible for team care, including recent readmissions of acutely intoxicated alcoholics, readmissions for transfer to lesser care level facilities, and certain diagnostic admissions. Finally, during certain periods of 1970 and 1971, the number of teaching teams and geographic areas was reduced because of an insufficient number of interns, leading to a reduction of the number of patients who could be accepted into the team care program during those rotations.

Within reasonable limits, degrees of flexibility to promote greater efficiency and smoother function of team care have been encouraged. For instance, if both the intern and resident are unable to attend a new admission promptly, the private physician may write orders to assure patient care and comfort. As house staff members develop maturity and earn the confidence of the community physicians, greater discretion is permitted regarding the strict requirement for immediate communication with the practitioner following the initial intern-resident evaluation. However, certain aspects of team care are fundamentally not susceptible to compromise or loose interpretation, and success of the strategy is dependent upon firm commitment of all involved personnel to these principles.

RESULTS

The great majority of patients are admitted by private physicians, 94.3 per cent of all 3,358 medical discharges during the study year 1970 (Table 1). Only 190 discharges (5.7%) were non-private. Of the 3,168 private patients, 2,358 (74.4%) were entered on team care, while the remaining 810 patients constituted the actually "private" service.

TABLE 1.—Distribution of discharges
January-December 1970.

	NUMBER	% OF TOTAL	% OF ALL PRIVATE
Staff	190	5.7	
Team Care	2358	70.2	74.4
Private	810	24.1	25.6
TOTAL	3358	100.0	100.0

Increasing participation in team care is demonstrated by the steadily rising number and per cent of private patients entered on team care, from the 1967 level of 922 (38% of private discharges) to 3,168 (74%) during the study year (Table 2). Staff in-patients declined from 335 to 190 during the same four year period. Corresponding figures show a similar 40 per cent decline in out-patient clinic visits during the four year period (Table 3), despite vigorous efforts to maintain the census of non-private patients.

TABLE 3.—OPD visits (fiscal year).

FISCAL YEAR	NEW	REVISITS	TOTAL
1965-1966	833	26,794	27,627
1966-1967	1,038	24,467	25,505
Total: 65-67	1,871	51,261	53,132
1969-1970	634	16,811	17,445
1970-1971	603	13,960	14,563
Total: 69-71	1,237	30,771	32,008

Of 165 physicians admitting to the medical service during 1970, 146 (88.5%) participated in the team care program (Table 4). Sixty-six (82.5%) of 80 doctors admitting six or more patients to medicine also admitted six or more patients to team care; only two of these 80 (2.5%) failed to participate in team care at all. Only four physicians of the 99 who failed to enter at least six patients on team care had more than eight admissions to medicine.

When basic PAS-MAP parameters are compared, the team care and the private populations demonstrate great similarities in characteristics (Table 5). There were no significant differences between such parameters as age, deaths, autopsy

TABLE 2.—Discharges from medicine by years.

YEAR	STAFF	TEAM CARE	PRIVATE	TOTAL	PRIVATE INCLUDING TEAM CARE	% TEAM CARE OF PRIVATE
1967	335	922	1,480	2,737	2,402	38.38
1968	241	1,554	1,347	3,142	2,901	53.57
1969	345	2,436	794	3,575	3,230	75.42
1970	190	2,358	810	3,358	3,168	74.43

TABLE 4.—*Team care participation of physicians admitting to medicine.*

	NUMBER	PER CENT
Physicians admitting 1 or more patients to Medicine	165	
Physicians admitting 1 or more patients to Team Care	146	88.5
Physicians admitting 6 or more patients to Medicine	80	
Physicians admitting 6 or more patients to Team Care	66	82.5
Physicians admitting 6 or more patients to Medicine but not participating in Team Care	2	2.5
Physicians not participating in Team Care but admitting to Medicine	19	
Physicians not participating in Team Care but admitting 6 or more patients to Medicine	2	10.6
Physicians admitting less than 6 patients to Team Care	99	
Physicians admitting 8 or less patients to Medicine	95	96

TABLE 5.—*Comparability of patient problems.*

PARAMETER OF COMPARABILITY	PRIVATE SERVICE 810 PATIENTS		TEAM CARE SERVICE 2358 PATIENTS		P VALUE
	No.	%	No.	%	
BASIC DATA					
Percent males		48		52	>0.10
Age 65 or older	260	32	804	34	>0.10
Deaths	52	6.4	137	5.8	>0.10
Autopsy performed	17	33	45	33	>0.10
FINDINGS ON ADMISSION					
Urinalysis					
sugar positive	73	10	260	11	>0.10
albumin positive	190	25	597	26	>0.10
Hematocrit below 30%	44	6	131	6	>0.10
WBC over 10,000	241	31	718	31	>0.10
Diastolic BP over 100 mm	129	16	376	16	>0.10
Temperature 100° or over	125	16	291	12	>0.10
MANAGEMENT					
Patients operated	91	11	271	11	>0.10
Percent with consultation		32		33	>0.10
Blood transfusions	46	6	167	7	>0.10
Parenteral fluids administered	185	23	482	20	>0.10
Antibiotics administered	248	31	721	31	>0.10

TABLE 6.—*Diseases most commonly encountered.*

DIAGNOSTIC CATEGORY	810 PRIVATE SERVICE			2358 TEAM CARE SERVICE		
	Rank	Rel freq %	Cum freq %	Rank	Rel freq %	Cum freq %
Other Heart Disease	1	9.4	9.4	1	11.7	11.7
Other Respiratory Disease	2	7.3	16.7	2	8.9	20.6
Central Nervous System Vascular	3	7.2	23.9	5	6.4	27.0
Pneumonia	4	6.9	30.8	3	7.8	34.8
Infective	5	6.8	37.6	4	6.7	41.5
Adverse Effects	6	6.7	44.3	11	3.5	45.0
Genitourinary	7	5.3	49.6	14	2.8	47.8
Diabetes Mellitus	8	4.6	54.2	6	5.4	53.2
Upper Gastrointestinal	9	4.3	58.5	10	3.6	56.8
Mental	10	4.2	62.7	13	2.9	59.7
Symptoms	11	3.8	66.5	8	4.0	63.7
Ulcer	12	3.6	70.1	9	4.0	67.7

percentages, admission findings, incidence of surgery or consultation, transfusion, parenteral fluid therapy or antibiotic treatment. A similar striking comparability exists among categories of diseases encountered between the two groups (Table 6).

Upon comparing the two sets of statistical descriptions which collectively form the patterns of practice, similarity was encountered except in three instances (Table 7): A significantly greater number of private patients over age 40 who underwent surgery failed to have a chest x-ray examination during the hospital stay compared to corresponding team care patients; 10 per cent of private patients who expired after the second hospital day did not have minimal laboratory studies recorded, compared to three per cent of corresponding team care patients, also a statistically

significant difference; finally, there was a significant difference between the 15 per cent figure reported for funduscope examinations recorded in the private service records, compared with the 31 per cent reported for team patients.

Discrepancies between the figures reported in the PAS-MAP report and those actually found by the authors were uncovered upon reviewing samples of the medical records for results of rectal examinations and funduscope examinations. These discrepancies were greatest among the funduscope data, amounting to 160 per cent (39% found compared to 15% reported) for private patients, and 94 per cent (60% found, 31% reported) for team cases (Table 8). Additionally, 65 of 215 private charts were found to be actually team care cases, an error of service clas-

TABLE 7.—Patterns of practice as reflected by PAS-MAP reports.

PARAMETER	PRIVATE SERVICE		TEAM CARE SERVICE		P VALUE
	No.	%	No.	%	
Variety Index (No kinds of dx tests/pt)	16		17		
Patients with multichannel chemistry	653	81	2,168	92	>0.10
No WBC on admission	20	2	29	1	>0.10
No urinalysis on admission	45	6	56	2	>0.10
No hematocrit on admission	21	3	27	1	>0.10
Minimum lab not met, total workup	49	6	59	3	>0.10
Patients with repeat EKGs	158	42	505	42	>0.10
Patients with diagnostic radioisotopes	162	20	470	20	>0.10
Patients with chest x-rays	453	56	1,435	61	>0.10
Abnormal results, chemistries	1,620	47	5,451	48	>0.10
Abnormal chemistries not repeated	919	57	3,240	59	>0.10
Number patients operated	91	11	271	11	>0.10
Consultations		32		33	>0.10
Total patients transfused	46	6	167	7	>0.10
One unit transfusions	5	11	16	10	>0.10
Per cent packed RBC		26		25	>0.10
Patients given parenteral fluids	185	23	482	20	>0.10
Patients given inhalation therapy	75	9	291	12	>0.10
Patients given cardiac regulators	145	18	429	18	>0.10
Patients given antibiotics	248	31	721	31	>0.10
Patients given tranquilizers	321	40	913	39	>0.10
Admissions—per cent emergency		27		19	>0.10
Admissions—percent urgent		21		21	>0.10
Patients transferred to home care	19	23	73	31	>0.10
Per cent patients with rectal exams		10		18	>0.10
Per cent patients with funduscope exams		15		31	<0.02
Deaths	52		137		
Autopsy	17	33	45	33	>0.10
Deaths 3rd day or later, minimum lab not met		10		3	<0.10
Patients on antibiotics without culture	54	22	103	14	>0.10
Operated patients over 40	70		215		
no chest x-ray	25	36	61	23	<0.10
no EKG	28	40	85	40	>0.10
no blood sugar	8	11	13	6	>0.10
no nitrogen derivatives	9	13	12	6	>0.10

TABLE 8.—Frequency of rectal examinations and funduscopic examinations as recorded in the medical record.

	RECTAL EXAMINATIONS		FUNDUSCOPIC EXAMINATIONS	
	No.	%	No.	%
Private				
150 cases	32	21	59	39
PAS-MAP		10		15
% discrepancy		110		160
Team Care				
150 cases	32	21	90	60
PAS-MAP		18		31
% discrepancy		17		94

sification within this sample of 30.2 per cent (Table 9). There was no corresponding error involving team charts being misclassified.

TABLE 9.—Private cases found to be team care cases.

	NO.	%	NO.
Cases reviewed	215	100	
Private	150	69.8	
Team Care	65	30.2	
Total Private reported			810
Total Team Care reported			2,358
Additional Team (+ 30.2% of 810 Private cases)			245
Total calculated			
Private (810 - 245)	565	17.8% of all private patients	
Team Care (2,358 + 245)	2,603	82.2% of all private patients	

The 810 private patients were hospitalized for an average stay of 11.8 days, while the corresponding figure for the 2,358 team care patients was 10.2 days. When only those patients staying less than 100 days were considered, however, the average stay for 808 private patients was 8.4 days, while 2,355 team care patients stayed an average of 9.7 days (Table 10).

TABLE 10.—Average hospital stay.

	PRIVATE	TEAM CARE
Total Patients	810	2,358
Average Stay Days	11.8	10.2
Patients Staying Less Than 100 Days	808	2,355
Average Stay Days	8.4	9.7

DISCUSSION

The team care concept has served as our vehicle for the evolution toward three major directions of the Department of Medicine: (1) Increasing involvement in programs of undergraduate and graduate medical education for physicians-in-training; (2) Effective delivery of optimal levels of medical care to all segments of the community served by the hospital; (3) Development of an approach to maintaining clinical competence for the private physician.

1. Involvement in Medical Education

The limited number of patients available for teaching in the clinical years had long been recognized as a factor impeding the advancement of production of physicians.²¹⁻²³ Recognition by the academic sector of the potentials provided by private patients for teaching programs was early reflected by its consideration as one of a number of possible topics considered for discussion by those professors of medicine whose initial meeting in 1954 led to the formation of the Association of Professors of Medicine.²⁴ Also, the educational contributions which could be made by clinicians "doing their thing" in good, well-staffed community hospitals has not gone unnoticed.²⁵ However, resolution of the many thorny problems associated with establishing an ongoing academic program using private patients for teaching in the following one and one-half decades had been largely unsuccessful, and such proposals characteristically fail to evoke enthusiasm from members of the faculty.

Yet even prior to the advent of third party financing and the decline in numbers of staff patients, populations of private patients were recognized to far exceed non-private teaching patients, community hospital beds far outnumbered university hospital beds, and university teaching hospital admissions constituted less than 15 per cent of all hospitalizations across the country.⁸ Following the enactment of Medicare and Medicaid, the shrinking non-private services have become even less adequate to provide the variety as well as the number of patients to sustain teaching programs.²⁶

Patients admitted by private physicians to community hospitals should be especially suitable for the education of physicians-in-training, since they reflect characteristics representative of the profile of the community such as ethnic, socioeconomic and other ecologic influences, as well as presenting a more realistic cross section of illnesses that

occur within the population. Additionally, these subjects allow students access to another vital factor often unavailable on non-private services, a setting in which to deal with sickness and interact with patients of all levels of verbal facility and educational attainment. Educators have been chided in the past for emphasizing the esoteric at the expense of developing depth of knowledge about commonly encountered conditions.²⁷

The opinion is widespread that medical schools and medical centers will need to expand their own facilities to include a much larger proportion of primary care or will have to affiliate with the community institutions which offer such services.^{14, 28} In discussing the Mount Sinai concept, Popper envisions the emergence of new types of "generalist" physicians, and even specialists in delivery of care, which could follow as a result of deep involvement in community hospitals by medical educators.²⁹

Even the American Medical Association is reversing a long-held position on the issue of supporting federal funding for training in specific disciplines, to the extent evidenced by a report that its Council on Health Manpower would now condone such federal aid, and endorse the Comprehensive Health Manpower Training Act of 1971 (PL 92-157)³⁰ which provides capitation grants to teaching hospitals for the training of house officers in primary care specialties.^{31, 32} Since between 85 to 94 per cent of medical students go out into the real world to practice medicine,^{11, 25} it is incumbent upon programs to provide realistic milieus for these students during their formative periods.

By what feasible or practical approaches can private patients be directed into the mainstream of the medical educational process? The reasonableness of redirecting current efforts is undeniable, but because of seemingly unsurmountable difficulties in the jurisdictions of educational principles, economics and communications, progress toward these goals has been disappointingly slow.

The effects of team care

Implementation of the team care concept at SFH enabled us to expand our internship and residency training programs in internal medicine, as well as to begin to provide the fledgling two-year School of Medicine with clinical material for their students, despite a 43 per cent decline in staff patients between 1967 and 1970. Countering this trend, the increase in team care cases from 38 per cent of 2,400 private discharges to 74 per cent of nearly 3,200 private cases during this same

period was a vital factor contributing to the increased attractiveness of our program (eight of our nine medical residents in 1971-1972 had been members of our house staff during the preceding academic year), and its continuing growth, with our establishment in 1971 of full-time formal training rotations in three other community hospitals in Honolulu.

The acceptance of team care by private physicians and their patients is reflected by their wholehearted and continued participation. Of 165 physicians admitting to the medicine service during the study year, 146 entered at least one patient on team care; 66 of these doctors admitted six or more team care patients; of the 99 remaining who admitted fewer than six to team care, 95 (96%) also admitted a total of eight or fewer to the medicine services as a whole (Table 4). Furthermore, only two of 80 physicians admitting six or more to medicine did not participate in team care.

Despite periods of relative unavailability of team care beds because of staffing shortages, only four physicians who admitted more than eight patients to medicine failed to enter at least six patients on team care, reflecting again the overwhelming support of the community physicians. It is reasonable to infer that these figures reflect high degrees of patient satisfaction as well, since these are discharge data describing conditions at the end of a period of hospitalization under team management.

Of the 66 clinicians who admitted six or more patients to team care, 33 were generalists, while 33 were internists and other medical specialists. Staff privileges are awarded according to an open staffing system, accounting for the broad range and large number of physicians admitting to medicine. In these respects we are organized virtually precisely according to the community hospital structure encouraged by Kerr White, in which appropriate resources are allocated to the general practitioner to facilitate his hospital practice.³³ He is not only represented politically by the Department of General Practice, but he works in, uses the beds of, and may also participate actively in the decisions of, the Department of Medicine or Surgery as well.

During the study year, over three-fourths of the house staff experience was provided exclusively with private patients entered on team care by these community physicians. Thus, a large segment of their 24 months of meaningful patient responsibility in the broad field of internal medicine involves delivery of primary care to patients of private practitioners of this art in the community.

The teaching attending physician

The key member of our primary team is the educator, or faculty member, the so-called teaching attending physician. He is an additional team member, supplementing the accepted teaching unit⁹ of the intern, the resident and the patient's private community physician and comprising with them what are called the primary members of the team. Functioning in the same capacity as the familiar "on service" attending physician in the traditional staff or non-private services, one TAP serves as the faculty member for each of our four geographic teaching medical wards for a two month period, conducting regularly scheduled in-depth bedside teaching rounds with the house staff, and being available to them at any time for consultation and advice.

It should be reiterated at this point that the TAP functions in addition to, and not instead of, the patient's private physician. *The latter continues to maintain his usual patient-doctor relationship, his ethical and medicolegal responsibilities, and his right to his fee for professional services rendered.*

Our teaching services thus differ significantly from those programs without TAPs, in which the house staff receives supervision and guidance through rounds conducted by private physicians, but only on their own private patients. This latter arrangement was specifically criticized by the Residency Review Committee in Internal Medicine in 1970,²⁶ although direct reference to such proposals was palpably deleted from amendments to those sections of the revised standards as approved by the Board of Regents of the American College of Physicians in 1971.³⁴

Physicians serving as TAPs are selected on the basis of capability, willingness to teach, and understanding of human interaction. Our experience at SFH parallels Hortenstine's estimate that approximately half of the medical staff of any sizable community hospital is capable of excellent clinical instruction,³⁵ and many of these seasoned clinicians possess expertise in skills considered essential but often neglected in recent medical curriculum.²⁵ That they are well trained is recognized by Freymann, who identified 70,000 specialists certified since 1945 as the "third force" of highly educated, technically skilled group of physicians who are members of staffs of community hospitals.³⁶ Sharing the convictions of Engel, who concluded that today's schools have failed to prepare students to understand patients and the human problems of illness,³⁷ we have attempted

to blend our TAP assignments so that active clinicians demonstrating these skills are available to help other team members gain confidence in meeting emotional and human needs of the patients. We have encouraged participation of these well-respected clinicians since their involvement and endorsement have contributed greatly to acceptance of team care. Over the initial years of operation, our TAPs have come predominantly from the ranks of private internists most active at SFH, and from the full-time faculty at the School of Medicine.

Since three of our four geographic teaching units are composed exclusively of team care beds, the TAPs assigned to those teams must be particularly adept at relating to others in a constructive manner, and in particular must be ever cautious not to offend the team care patient's private physician, with whom he may be in direct professional and economic competition. It should be reiterated that participation in team care is voluntary. Practitioners retain the option at all times to remove their private patients from the team care service, should dissatisfaction arise over any arrangements involving their patients. Although every team care patient whom the TAP encounters on rounds represents a potential source of conflict between himself and the patient's private physician, as our system has evolved, a spirit of mutual trust and understanding has developed among all members of the team, resulting in smooth and successful acceptance of the system.

2. Delivery of Medical Care

Public attention is focused as never before on the discrepancies between the capability of medicine and the actual delivery of health care.^{2, 3, 37} We are faced with an insoluble problem of matching the wants of the consumer, their needs, and the available resources.^{38, 39} Though this so-called health care "crisis" has been with us for a long time,³ we have been spurred on by the conviction that at no time has the need been greater to develop means of delivering to as many people as possible as high a level of medical care as is feasible within our resources.

That the primary purpose of the medical department of the community hospital is medical care and service to the community was recently reaffirmed by the American College of Physicians' Committee on Hospitals.⁴⁰ In discussing multiple offsetting factors affecting the current health delivery system and today's physician, Friedman concluded that the coordination of these factors has been found to be most effective in hospitals,

which more and more are satisfying the technical and social needs of both physicians and patients.⁴¹ Even though the vast majority of patients are not hospitalized, hospitals have been identified as the principal organizing focus of a new and more effective system for the delivery of health care.⁴²

Organized medicine has encouraged innovations in delivery systems of health care while cautioning against disruption of the continuity and balance of health services provided throughout the community.¹⁷ The 89th Congress mandated such an evolutionary approach in its major pieces of health legislation, PL89-749 Comprehensive Health Planning (CHP) and PL89-239 Regional Medical Programs (RMP). The purposes of CHP law, the first U.S. legislation using the general approach to health on the national level, included assuring comprehensive health services of high quality for every person "but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts,"⁴³ while RMP listed among its purposes "to improve generally the health manpower and facilities throughout the country without interfering with existing patterns of delivery, financing or administration of health services, both official and voluntary."⁴⁴

The effects of team care

What contributions can team care make to improve current delivery systems? Team care at SFH has allowed better use of available community hospital resources, without causing major disruptions of existing community patterns of delivery of hospital care, and without substantially affecting patterns of care provided.

Though the open staffing arrangement might seem a liability in planning a system of education and delivery, with 165 generalists, internists and other physicians admitting patients to 110 beds on the medicine service, the situation provided an unusual opportunity to affect delivery patterns of these practitioners, as well as to help to maintain competence for these physicians (vide infra).

Private patients placed on team care receive multiple benefits unavailable to those patients admitted to the private service. House staff members of the primary team available at all times in the hospital can provide team care patients access to quality care at all times, in the interval between routine admission until the busy practitioner can make his initial hospital visit, or between an emergency admission at night or on holidays until the arrival of the private doctor. Inclusion of as many practitioners in the community as possible allows

delivery of care to as broad a segment of the community as possible, while providing house staff access to a larger number and variety of patients.

Whenever a member of the team other than the patient's private physician initiates a productive diagnostic or therapeutic maneuver, a higher level of care is automatically delivered to that patient. The prompt recording of progress notes in charts of team care patients by the house staff facilitates better care in emergencies and cardiopulmonary resuscitations. Certain procedures are more likely to be performed on patients on team care because house officers are either more adept at the procedure (e.g., arterial puncture) or are available for immediate management and adjustment of treatment (e.g., respiratory therapy).

Is the quality of care delivered to the patient affected when he is entered on team care? Discussions concerning the quality of health care must be prefaced by the realization that present methods to assess quality are inadequate; Ingelfinger says, "Additional methods to assess the quality of that care are sorely needed."⁴⁵ Though monitoring of the outcomes or effects of the health care process on the health of the consumer is ideal, this has been virtually impossible on a workable scale.⁴⁶

As a result, increasing attention has been directed towards monitoring the process by which care is given, as reflected by the extent to which it is recorded in the medical record. Yet Murnaghan and White question whether one can reasonably expect to abstract reliable information from the average medical record in its present state of disarray.⁴⁷ The shortcomings of using records to assess quality of medical care have also been reviewed by Fessel and Van Brunt, who caution that conclusions based on review of the recorded process of care "may be incomplete and misleading."⁴⁸

With these limitations in mind, an attempt has been made to compare the quality of care provided during the study period by analyzing data obtained from the PAS-MAP presentations.⁴⁶ Patterns of care presented by the private and the team care groups of patients have been examined rather than analyzing data from individual patients.

The two groups of patients demonstrate comparability in virtually every respect, ranging from variety of diseases encountered, basic data and findings on admission, through investigation, management, death rate and autopsy percentage. To the degree that these patterns of care are measures of the quality of medical care provided, we conclude that the quality of care appears not to be compromised by team care, and in certain few respects placing a patient on team care appears to result in the development of a more favorable

pattern. Specific examples in which significant differences were found include the recording of certain fundamentals of the physical examination such as the fundoscopic procedure, and the completion of basic minimal laboratory studies among patients who expired after the second day following admission. Stapleton was similarly unable to demonstrate deterioration of medical care when he assessed the care provided by house staff on private patients without TAP supervision.⁴⁹

The large data-collection discrepancies encountered when the authors audited a sample of the medical records identify a particularly vulnerable, purely technical, weak link in the chain of process monitoring. Failure to reckon with such shortcomings can lead to inaccurate, even erroneous conclusions. For example, if the 30 per cent error in classifying team charts as private were applied to the total study year population, one could reasonably conclude that instead of the 74.4 per cent team participation figure accepted as the basic of our study, 82.2 per cent of all private cases were actually entered on team care (Table 9). Furthermore, discovery of abstracting errors of even greater degree, such as those ranging from 94 to 160 per cent indicated for the recording of fundoscopic and rectal examinations (Table 8), suggest the magnitude of potential misrepresentation should such data not be accepted without healthy skepticism.

Ongoing interaction among primary members of the team also exerts salutary effects on the maintenance of quality of care delivered. Each team member may affect the day-to-day process of care, based upon actual outcomes of the immediately preceding processes of care. We value this mechanism as being more comprehensive as well as probably of greater immediate and ultimate value than many traditional means, such as the retrospective hospital staff audit committee functions, daily admission rounds, chief and consultant rounds or even ongoing utilization review.

Does the involvement of house staff in the care of private patients result in any change in the length of hospitalization? When patients with hospital stays over 100 days were excluded, our team care cases demonstrated a 1.3 day longer stay than private cases. Patients in teaching hospitals, defined as those institutions with approved internship or residency programs, have been shown to have an average stay of 1.0 day longer than those in non-teaching hospitals. In presenting these CPHA data based on 1,283,000 teaching hospital patients and 814,000 non-teaching patients, Slee attributed the one-day-long teaching hospital stay to two factors: An additional 0.3 day was thought to indicate

differences in complexity of cases or differences in patient mix; the remaining 0.7 day was attributed to "teaching effect," possibly representing "effective hospital use in view of the mission of teaching institutions."⁴⁶

What can be concluded about the effect of team care upon effective utilization of hospital services? Analysis of data in much greater depth necessary to accomplish a valid retrospective utilization review is beyond the scope of this presentation. The variety index, the per-patient average number of different kinds of laboratory, diagnostic radiologic and other tests as recorded on the PAS case abstract, was essentially the same for private (16) as for team (17) patients. That patterns of investigation and management, spectrum of diseases encountered and incidence of consultation are similar also suggest that utilization did not differ materially between the two services.

Team care can provide numerous other benefits which, though manifest, are more difficult to measure. Such factors as the reassurance that patients may feel knowing they are on a teaching service, or the security coming from being cared for by more than one team physician, may promote patient satisfaction. Tension or apprehension on the part of nursing and other hospital staff concerning problems of management has been reduced by the presence of capable house staff members familiar with the physicians' routines, while physicians themselves are reassured that unexpected needs of their patients will be met by knowledgeable house staff. Attitudes and motivation of allied health personnel, nurses and house staff members can be improved by their own awareness that they too function as members of the team. The enhancement of morale among interns and residents attendant to their being regarded as colleagues and peers by the physicians within the team structure deserves particular emphasis.

The private physician has much to gain from discussions with his colleagues, whether or not they are primary members of the team. His time for direct patient contact and thoughtful unhurried interaction with other team members is increased by assumption by the house staff of certain "chores" deemed to have distinct educational value, such as preparing discharge summaries, writing orders, and recording histories and physicals. The stage is set to encourage private physicians themselves to function more efficiently in the knowledge that others' judgement may modify, amplify or even constructively contradict their decisions. Implications for medical care evaluation and quality control are obvious and over-

lapping. For example, the knowledge that every team care patient and his record is subject to presentation and review by the TAP as well as other team members has encouraged better record keeping and, to the extent that the recorded medical care process predicts outcome, delivery of care of a higher quality by the private physicians.

Besides providing actual supervision and education for team members, the TAP plays a key role in affecting the delivery process. He may function in several dissimilar capacities, serving as educator, unofficial consultant, critic, or student, often exerting his influence by setting examples for others to emulate. His regular presence also introduces to the physicians-in-training an example of a viable system of ongoing peer review.

Many commentaries have lamented the decline of the direct and personal attention given to patients by their physician.^{9, 50-53} The role of the TAP provides clinicians and academicians alike the chance to function and react in real world situations, providing direct patient care, and relating to all the levels of personnel involved. In predicting future trends resulting from the new requirements for the American Board of Internal Medicine, Rosenow challenges us to figure out ways in which internists with subspecialty interests can deliver the needed primary care.⁵⁴ Team care furnishes a mechanism within which these doctors can regain confidence and proficiency in primary care delivery in the broad field. Indeed, serving a two-month tour as the TAP, besides bringing them closer to the realities of health care in the community, makes available to some teachers the opportunity to again practice what they have recently only been preaching!

The team care concept introduces the physician to systems of team approaches rapidly evolving within the field of health care delivery.^{55, 56} There is growing recognition that there are fewer and fewer things which a physician can and should do individually that are based only on the data which he has been able to collect, and on his individual judgment. Evang's admonitions that in his own interest the physician should as soon as possible be formally and realistically integrated in a proper team, of which he will not necessarily regard himself as the leader,⁵⁵ have been echoed by Heard in his address to the 82nd annual meeting of the Association of American Medical Colleges.⁵⁷ The private physician functioning within the confines of our team care system is encouraged to establish his own personal acceptable limits of delegation of authority to others within a team framework, skills which will serve him well with the advent of new

types of physician support personnel.⁵⁸

3. *Maintaining Clinical Competence:*

The goal of life for a physician is not only continued education, but continued productivity.⁵⁹ Some of the basic concepts that distinguish a profession from a trade or a technological skill are that a profession requires "a lifetime of learning," and that members of a profession who possess a body of knowledge relating to the profession are obligated to teach others in the profession so that the people may be better served.⁶⁰ One of the major features of our team care strategy is that it possesses built-in means of providing continuing education of appropriate and extremely relevant content to those who might best benefit from it, under circumstances uniquely conducive to learning, with a surprisingly small investment of additional time on the part of the private community physician.

The needs

More effective methods for physicians to maintain competence are needed. Whether a clinician frets more over the proliferating medical knowledge, which supposedly has a half life of five years or doubles every eight years,⁶⁰ or is "hung up" on newer philosophies or systems of information retrieval or problem solving emerging long after his graduation,⁶¹⁻⁶³ he needs help. As plans are implemented to shorten the years of formal medical education,⁶⁴ the needs for viable systems of continuing education will multiply.

The National Advisory Commission on Health Manpower recommended exploration of relicensure of physicians in 1967.¹⁰ By 1970 response from organized medicine included encouragement by the AMA of specialty boards and specialty societies to consider establishing periodic recertification programs for continued membership. The American Board of Internal Medicine has now committed itself to the concept of voluntary recertification.⁶⁵ The chairman of the Association of American Medical Colleges recommended that the AAMC adopt a firm position on recertification every five years.¹⁶ The Oregon Medical Association, and subsequently the state medical associations of Pennsylvania, Arizona, New Mexico and Ohio require documentation of continuing education as a requirement for continuing membership.⁶⁶ Actions by numerous other state medical associations tend in a similar direction.^{67, 68}

Recent legislative action includes passage of the first periodic physician relicensure law in New Mexico in 1971, completion of a similar measure

in California in 1970, the implementation of which has been delayed for three years, and consideration of relicensure taking place by 17 of 38 state boards questioned in 1970.⁶⁷ In California over 100 hospitals require each staff physician to report yearly his continuing education experience as a prerequisite for staff appointment; and in 1970 the Joint Commission on Accreditation of Hospitals approved revised standards for accreditation of hospitals which indicated the responsibility and duties of the staff in the areas of medical care evaluation, peer review and continuing education.^{67, 68}

As society assumes responsibility for fulfilling the right of the individual to health care, so will society demand proof of competence of the providers. Indicative of future trends are two recent actions; a state court has judged that a physician's work no longer can be judged by the quality of practice in his immediate locality, but must be judged on the basis of what his peers know and practice, wherever they may be;⁶⁹ in New York, a regulation, not yet enforced, established criteria to prove competence which physicians must meet in order to be paid for care rendered under Title XIX (Medicaid).^{67, 68}

Two approaches

Recent trends reflecting the response of the medical profession to these increasing needs for ongoing continuing education have been amply summarized.^{60, 67, 68} The AMA Council on Health Manpower identifies two major approaches to maintaining clinical competence: (1) continuing education programs, and (2) medical care evaluation through practice observation.⁶⁸ Included among continuing education methods are the familiar continuing education courses, professional journals, audio tapes, scientific conventions, and local hospital presentations and staff meetings, as well as efforts nationally such as have been attempted through Regional Medical Programs, the National Library of Medicine and other federal agencies.⁷⁰ On the other hand, medical care evaluation activities encompass attempts to assess the quality of health care by studying either the health care process or the outcomes of health care, by such methods as peer review, audit committees functions, utilization review, and voluntary self-assessment examinations.

Paralleling the proliferation of methods designed to promote continuing competence is the increasing adoption of measures intended to ensure maximum physician participation. One may voluntarily qualify for recognition such as provided for by the AMA's Physician Recognition Award; however

one may face such restrictive or punitive measures as curtailment of hospital or other privileges, loss of membership in professional associations, withdrawal of certifications by specialty boards, non-payment of fees by third parties for services rendered, or even non-renewal of one's license to practice medicine. Despite all of these developments, however, serious questions still remain regarding the actual effectiveness of these efforts, particularly regarding evaluation and quantitation of the end product, the actual care rendered.

Effectiveness of continuing education questioned

Brown and Uhl, concerned that continuing education programs should be evaluated in terms of their effect on patient care, cite evidence that the standard types of courses, lectures, panels and seminars usually produce no significant change in physician behavior or improvement in patient care.⁷¹ Hess and Levitt state that the most critical dimension of performance, the application by the physician of his knowledge and his interpersonal and psychomotor skills to the patient, has escaped systematic and reliable evaluation under our present system.⁶³ Mueller maintains that it is a physician's performance "at work in a responsible setting" that must be assessed on a continuing basis, that performance at work (what a man does) rather than performance in examination (what a man knows) is the important element, and that present examination practices are not capable of accurately assessing continuing physician performance.⁷⁰ Even in experimentally attempting to directly relate observed changes in physician behavior to programs of continuing education, reference is made by Abrahamson to their frustration in their attempts to establish cause-effect relationships even with the "tightest experimental research design,"⁷² while Naftulin and Ware could not demonstrate any improvement of clinical competence despite an enhancement of "basic skills" among psychiatrists enrolled in a continuing education course in preparation for taking their specialty board examinations.⁷³

Inherent shortcomings of current approaches for maintaining competence have underlined the urgent need for better systems of accomplishing the task. Besides exhibiting the undesirable features characterizing episodic programs, the available instructional courses share with other continuing education programs the basic weakness of demanding significant time commitments on the part of the busy practitioner. Dimond's remarks in addressing this issue deserve reemphasis.⁷⁰ Since they question the value of these standard types of

courses, lectures and seminars to begin with, Brown and Uhl argue that participation by busy physicians in these programs will further discourage them from being involved in other experimental projects which might ultimately prove to be of greater value.⁷¹ Schemes which either confer awards or threaten restriction of professional activity or status tend to motivate least those who need it most, as do also self-assessment examination and hospital staff activities.

On a national scale, after six years and a recent redirection of missions, serious questions remain about the past record and probable future accomplishments of Regional Medical Programs (PL89-239)⁷⁴ which were initially mandated to promote education, research, training and demonstrations along categorical approaches. Ellwood has cautioned that if these programs become advocates of the status quo, as many of them appear to be, they might actually impede the introduction of basic reforms in health delivery systems.⁷⁵ Furthermore, national concern has again been raised over the ability of professional associations, despite their dedicated educational efforts, to control the quality of performance of its members.⁷⁶

Validity of evaluative approach also challenged

On the other hand, the validity of evaluative studies of practice observation as a reflection of the actual care delivered has also been challenged, peer review has been labelled consistently inadequate to guarantee high standards of physician performance,⁵⁹ and there is consensus that the educational value of these instruments has remained potential, especially those attempts to extend peer review to the extrahospital setting to reach practitioners without hospital privileges.^{59, 68, 72} As increasing social concern underscores growing needs to measure physician competence, greater emphasis is being placed on evaluating the quality of medical care as reflected by data abstracted from medical records.

As an example, the Hawaii Medical Association is now proceeding to extend its pioneering process-monitoring effort assessing ambulatory care physician performance, in which data obtained in the first such study on a statewide basis was compared with information gleaned from a similar review of hospital medical records.⁷⁷ Initiated as an attempt to assess the quality of health care delivered by monitoring the process, as reflected by their medical records, by which physicians arrive at diagnoses, this effort contains methodology for assessment of outcomes through its ambulatory care phase.

But Murnaghan and White caution that much upgrading of the state of the art of amassing, standardizing and handling data is necessary, and progress awaits major basic technologic and attitudinal improvements such as changes in the approaches to patient care, improvement of medical records, and promoting comparability of data collected by the numerous systems now available.⁴⁷ Moreover, education efforts based on these methods of practice evaluation have yet to exert a meaningful influence on physician behavior, nor does Mueller expect much to change until much greater effort and commitment is evidenced by the medical profession.⁵⁹

Contributions of team care

We believe the team care strategy can serve as a major instrument to promote maintenance of clinical competence by all categories of physicians. Relevant, individualized continuing education under conducive learning conditions for members of our medical staff is constantly available on team care, in return for only minimal demands on the physicians' most precious commodity, their investment of time. Additionally, ongoing reappraisal of continued physician performance by objective examination of his "work-performance-record,"⁵⁹ the patient care evaluation that Brown and Uhl identify as "first level" evaluation,⁷¹ has not only become feasible within the structure of our team care system but could evolve into a practical form of real peer review—physician-implemented approach to the evaluation of actual care rendered. We too prefer this approach over the alternative of evaluation by lay examiners, the prevalence of which can be at least partially attributed to default on the part of the profession.

Within the educationally-oriented team care strategy, community physicians continue learning whether as teacher or as student, remaining vitally involved in the regular interface and discussion with professional peers, of identified and specific clinical problems and treatment modalities, thereby practicing the method which has been judged as being "possibly unequaled" for improving clinical competence.⁶⁸

Following a brief adjustment period, community physicians and house staff members have developed comfortable and mutually profitable ongoing relationships, while the TAPs and chiefs serve as teachers, arbitrators and solvers of tough problems. Other team members motivate learning on the part of the community physician not only by variously assuming their appropriate roles of student or teacher, but also emphasizing subjects and

topics whose relevance is automatically assured by the identified deficiencies as well as by the features presented by the physician's own private patient. By supplying him the means with which he can more clearly identify his own limitations, the team helps him in effect to recognize his own needs as well. In addition, feedback evaluation of his current educational needs by TAPs and house staff members guides our director of medical education in assessing deficiencies and developing educational presentations, including those of the more traditional types, to fill these gaps. Built into the team care system, then, is the mechanism of individualization which encourages the practitioner to learn just what he needs at the time when he is most receptive to learning it.

Besides featuring the effective learning techniques of repetition, problem solving with feedback, and active learner participation, the daily ongoing characteristics of team education produce reinforcement of subject matter in proportion to their frequencies of occurrence for that particular practitioner. For example, various aspects of heart failure or of depressive syndromes will appropriately be considered more often by a particular private physician with team members because more of his patients will present facets of those diseases.

We have previously noted that whenever another team member improves upon the performance of the private physician, whether in terms of diagnosis, management or promptness of delivery, the patient in effect receives a product of higher quality. By allowing the house staff to write the majority of the orders, the community physician enters into a reciprocal obligation with other team members to keep abreast of each other. Furthermore, the physician is himself emotionally coerced to develop facility in understanding and handling the newly acquired knowledge upon which he must plan subsequent patient management, communicate with the patient's family, and maintain peer relationships with other team members, who as Dimond astutely observes, "will act as living stimuli and whose very presence provokes from the physician the very need for information."⁷⁰

The team care system has convinced us that continuing education for the community physician with an improvement of the delivery of medical care is both feasible and practical in the community hospital setting. Parenthetically, Torrens and Weinstein had documented the inability of urban teaching hospitals to serve these needs of the community physicians in New York City.⁷⁸ Rather, these daily, ongoing educational activities

will best succeed in maintaining the competence of the physician and the delivery of his quality product if they are carried out in his usual work setting, the community hospital.

Efforts to involve the community hospitals as learning centers have thus far been largely confined to pilot and model projects based upon technological advances in communications systems.^{71, 79} Yet most of these very community hospitals have the greatest need for a system of continuing education, and successful implementation of such a system on the community level could bring about the "quickest and most satisfactory improvement in our national standards of health and medical care."⁸⁰

Though the much larger and heterogeneous attending staff resulting from our open staffing system presented serious challenges initially, we have seized upon this opportunity at SFH to affect physicians demonstrating a wider range of competence, and have charged our teams to offer more help to those who might need it. Actually there is a definite tendency for this to occur spontaneously anyway, as evidenced by the observation that the highly trained internists more often exercise their prerogative to write a significant proportion of the orders on their own patients placed on team care, while doctors with less formal training delegate greater authority to house staff members. Thirty-three of the 66 doctors admitting six or more patients to team care were non-internists, indicating the spectrum of physicians who could be reached by team care.

As universities heed their mandate to increase their involvement in graduate and continuing education and affiliate with these community hospitals, they will become aware of several other potential strengths within these institutions. Concerning teaching manpower, Hortenstine's estimate of about half the community hospital's medical staff being capable of excellent clinical instruction³⁵ and Freymann's "third force" of highly educated, technically skilled group of physicians based in community hospitals³⁶ have been mentioned previously in the consideration of potential TAP resources. While deploring the exclusion of practicing internists for major teaching roles, with consequent loss of impact upon medical students and house staff and loss of impetus for continuing education on the part of senior physicians, Young indicates that at the University of Rochester half of the total undergraduate instruction of medical students is conducted outside the University Medical Center with the help of 88 per cent of all board-certified internists in Rochester, and these

internists in turn have been awarded faculty appointments in the medical school.⁸¹ Moreover, directors of medical education in many unaffiliated community hospitals have begun to effect attitudinal changes among more conservative elements of medical staff which can lead to acceptance of team care concept. In the area of medical care evaluation, our hospital stands among the one-seventh of the nation's hospitals which participate in the Professional Activities Study (PAS) of the CPHA, which can provide extensive in-depth studies reflecting observations abstracted from medical records of 30 per cent of the country's short term general hospital discharges.⁴ Universities can appropriately exploit opportunities in these community institutions for research into ongoing peer review and medical care evaluation through practice observation, using approaches involving TAPs and other professional observers.

INCENTIVES

Success of the team care strategy in general, and of the continuing education aspects in particular, depends upon widespread, voluntary and continuing support by all community physicians who admit patients to SFH. What incentives are built into team care which encourage this broad-based participation? Perhaps the most crucial factor concerns the reassurance to the community physicians that as they as well as their patients benefit from team care, there will be no interference with or disruption of the traditional patient-doctor relationship, or of the attendant economic, ethical and legal arrangements.

While enabling a higher level of care to be delivered to their patients, practitioners have benefited from the continuing education programs without fears of direct economic competition, and the increasing proportion of physicians participating in team care reflects their confidence in our intentions. An initial fear that patients might be proselytized by TAPs has been proven unfounded by the test of time; rather, a description that makes the rounds from time to time is that Team Care can mean free consultation for their patient.

The matter of efficiency is another common denominator which wins converts to the cause of team care. Busy practitioners with little time for continuing education are nevertheless thought to be interested if only something convenient, worthwhile and efficient could be offered.⁷⁹ In proposing to relieve these busy physicians of certain routines in return for the privilege of sharing in their cases, we in effect trade off their time spent in chores for a short period of two-way education, but make no

significant additional demands on their rounding time. We have often observed that these private physicians, skilled in the nuances of human interaction and wise in the art of medicine, can complement the approach of many TAPs, and as their image too is enhanced, favorable shifts in their priorities result.

Gratification of other needs on the part of the community physicians also motivates them to play the team care game. They can bridge the generation gap, establish social interfaces, and even develop relationships with house staff members leading to invitations to join them in private practice.

There is widespread realization among members of the profession that we could all do a better job, if we could just keep up to date.⁶¹ Castle and Storey maintain that all physicians are interested in learning when they have a need to know and when they are able to get help on their own terms.⁸² Team care allows physicians the incentives of learning and functioning in the face of challenges without imposing feelings of being threatened or intimidated. An arena is devised where education can occur and where attitudes can change, gracefully and without loss of face or threat to the ego. Indeed, through the team care concept, help is truly available "on their own terms."

FUTURE TRENDS

Our experience with the team care approach to solving our own pressing problems in health education and delivery has convinced us that this system can make a real and significant contribution on a broader scale. The success of team care depends primarily on attitudinal shifts and behavioral adjustments on the part of practicing community physicians, and we believe these have been sustained by our staff members far longer than might be expected had these phenomena been merely an expression of the "Hawthorne Effect"⁸³ of transient effects due to initial enthusiasm. In return we have been able to fulfill needs and continue to supply incentives for our staff members with virtually no additional investment in resources or cost over these five years. In a more formalized setting with appropriate financing and planning, more elaborate and encompassing arrangements will evolve to meet the needs of universities as they implement their roles within and beyond the 20 per cent of this nation's hospitals which presently have teaching programs.

By appropriately recognizing the status of the community physicians and engaging them in regular interface concerning their own problems, the academic sector will make strides in dispelling the "town gown" syndrome while carrying out their

proper roles of thoughtfully effecting and overseeing changes in education and delivery. Team care provides the mechanism for bringing many skilled community practitioners back into the university structure where they rightfully belong by utilizing their specific expertise as they serve as TAPs; more significantly, team care can attract non-affiliated practitioners back to hospitals where they can deliver better primary care with better continuity, while simultaneously availing themselves of a proven continuing education mechanism. Elements of the team care strategy could facilitate success of the Area Health Education Center programs¹³ which Gordon, in considering the national problem of uneven physician distribution, suggests might initially be developed centering around community hospitals that now have postgraduate training programs.⁸⁴ Furthermore, team care can serve as the vehicle for universities to facilitate the next steps, involvement with unaffiliated or unapproved hospitals in more remote areas, where the needs which can be met by this strategy may be even more acute.

For newly emerging schools of medicine including that at the University of Hawaii, team care holds particular attractiveness, not only because of the flexibility and independence which newness or smallness should confer,⁸⁵ but also because of the closeness and freshness of venture which should initially characterize the relationships between community physicians and the new school. In a candid review of present directions in medical education, Danforth challenges medical schools to give thought to identifying unique and special roles in which they might excel. He makes a plea for each to embrace certain particular challenges and responsibilities leading to increased institutional individuality after carefully assessing its own peculiar opportunities, history, geography and personnel.⁸⁶ Our emerging school in Hawaii can capitalize on this opportunity to experiment and enlarge upon the functioning team care model and explore those real and potential advantages, while fully exploiting the expertise and enthusiasm of substantial numbers of community physicians already familiar with the mechanics of the system.

Team care holds promise of being a training ground in which a new breed of specialist could be spawned, a doctor skilled in understanding and bridging disputes, both intra and inter-professional. Medicine will also need more of these creatures as we deal increasingly with legislators, third parties and others outside the profession.

Not to be overlooked are the far-reaching impli-

cations of the built-in mechanisms for ongoing peer review, conducted by real peers in the true sense, performing medical care evaluation through ongoing practice observation in the actual work setting. Additionally, opportunities for educational rather than punitive responses are immediately available, and evaluative measures can logically follow with only minimal adjustments of existing hospital procedures.

Team care does not succeed by fiat. Nor does team care, or any other arrangement, succeed because "control" is assumed by or vested in a group of "outsiders," no matter how well-meaning or sincere. On the contrary, team care succeeds because physicians' skepticism and attitudes are overcome by gradual and patient efforts demonstrating the efficiencies of the strategy to the busy community physicians, while preserving for each his most valued of his unalienable rights, his time, and his traditional patient-doctor relationship. Team care represents an acceptable compromise, delegating to the academicians full responsibilities in their areas of expertise, while providing them a forum in which they can maintain perspectives by participating in regular interaction with practitioners, patients, students and other health team members. Team care succeeds because there is something in it for everyone, and because everyone involved in team care *wants* it to work.

In the words of the Carnegie Commission on Higher Education, "this is a propitious time to act."¹³ Replication of team care in community settings can enable universities to simultaneously carry out several of their primary missions. We believe team care can serve as a practical functioning prototype on which workable arrangements can be designed to begin solving many of today's health problems.

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Bernard J. B. Yim, M.D., who coined the term, "team care," and played a major role in the development of the concept, while serving as chief, department of medicine, St. Francis Hospital, 1965-1967.

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Presidential Address

*Presented at the 116th Annual Meeting of the
Hawaii Medical Association, May 12, 1972.*

HERBERT Y. H. CHINN, M.D., *Honolulu*

DR. UEMURA, DR. HALL, ladies and gentlemen of the medical profession, and the community it serves, and guests.

I am honored to have this opportunity to speak to you tonight. The medical profession, especially recently, has received undue criticism, in every facet of medicine, from vociferous, pontifical "eggsperts." Their aim is often bad, and all they do is scramble up the problem so badly, that before we can proceed, a crew is needed to clean up the mess. This does not mean that there are not some just criticisms, or that we fail to recognize certain deficiencies.

It's important to realize that the goal of the Hawaii Medical Association has always been to attain the best health possible for the people of Hawaii. In fact, Elliott Richardson, Secretary of HEW, and other authorities publicly recognize the fact that the health status of the nation, including its minority groups, has significantly improved over the years. Hawaii has one of the most favorable physician-population ratios, and according to Blue Shield, one of the lowest hospital utilization rates in the nation, approximately half that of the rest of the country. At the same time, its infant mortality rates are one of the lowest in the nation, and life expectancy is high. However, we are all aware of certain widespread problems in the health care delivery system which are threatening to overload the system and swamp the gross national product. As national health costs continue to rise, with the federal government paying $\frac{1}{3}$ of the health bill, great pressures are being exerted to streamline the system. We must not react to this pressure hastily, but determine what is truly best for Hawaii.

The Association is always interested in attaining the greatest efficiency possible in the delivery of medical care. However, we feel man is *not* a commodity like an automobile, and meeting his needs requires more than supermarket techniques. Insight and planning should be based on his spirit, as well as his body, in determining benefits received. The Hawaii Medical Association is investigating many ways to reduce costs. One of these is promoting the removal of barriers to proper care by insurance requirements which limit reimbursement to only certain types of care. Health Maintenance Organizations, or HMOs, encourage efficiency by removal of those barriers, as well as through their obligation to provide what is said to be comprehensive care on a prepaid basis. Theoretically this inspires efficient use of personnel and lowered utilization of hospitals. While we support the development of innovative ways to deliver health care, and feel this concept is necessary to explore on a limited, experimental basis, it must be pointed out that in this type of setting, just compensation does *not* follow from incentives to practice excellent medicine, as much as from efforts to lower hospital utilization and limit, or delegate, services. Whether or not this entire concept or parts of it prove wise, or acceptable, should be carefully weighed, and standards of optimum care should be set to assure continued quality.

Hawaii physicians have always had recognized levels for quality care within the profession. The Hawaii Medical Association, in an attempt to assure continued delivery of these high standards in all settings, sponsored Quality of Care studies of hospitals and private practices in 1969, with full cooperation of Hawaii hospitals and physicians. We are now involved in a continuing EMCRO

program (Experimental Medical Care Review Organization), through RMP (Regional Medical Program), which allows these standards to be put on a computerization basis for the purpose of continuing review, assessment and education. This unique study may serve as a basis for competent peer review in the future.

Recognizing the need to expand and improve emergency medical services in Hawaii, the Association is implementing the basic planning of Comprehensive Health Planning by submitting a proposal for funds to implement a statewide emergency medical services system. Along these lines, Hawaii Medical Association has also encouraged a Nursing Quality Care Study by a local hospital, in conjunction with the University of Hawaii School of Nursing, and has initiated a similar study for extended care facilities through EMCRO and the Honolulu County Medical Society.

It has been instrumental in helping the Medical School achieve a successful integration with local hospitals. The Association is also working towards the orderly development of *appropriate* allied health manpower, such as nurse practitioners, extended nurses and physician assistants, and is working with the American Nurses Association, Schools of Nursing and Medicine and various planning agencies in this field.

We believe all of these innovative programs must meet acceptable standards which do not compromise quality, but augment and compliment the delivery of medical care in Hawaii. Our profession is exerting its best judgment in attempting to guide these efforts.

But health is *more* than medical care. It is not an irreducible primary, but a composite of one's total way of life!

Health is a nebulous state affected by the values a person sets for himself by his life style, habits, economic situation, and environmental surroundings, as well as his genes and cultural habits.

The medical profession *cannot dictate* life styles which would reduce the number of persons killed by automobiles, or the deaths of young people from drug overdoses, or those courting heart disease and cancer by overeating or smoking excessively. It *alone* cannot promote better housing or less pollution.

Yet, we have voluntarily assumed responsibility in these areas through our committees' active efforts, in environmental health, automotive safety, substance abuse, mental health, and others, resulting in an 80% drop in the use of amphetamines within three months, the development of appropriate educational TV programs, placement of physicians in rural areas of shortage such as Wai-anae, legislative support and introduction of bills to benefit the health status of the people, voluntary staffing of drug, diabetic and other screening clinics, and numerous other directions.

The Medical Association is moving ahead on all fronts, and the *immense* potential of the HMA in helping solve Hawaii's health problems is only beginning to be realized. It is *imperative* that the physicians of Hawaii continue to form a united front in providing informed, effective leadership to promote the health of Hawaii.

In closing let me say I have greatly appreciated the opportunity to serve you as your president, and am deeply grateful for all the fine support I have received throughout the year.

You can be assured of my continued interest and active support.

Editorials

Team Care at St. Francis Hospital

At a time when peer review for quality control of medical services is much in the public eye, when cost control is concerning third parties, when residency training and continuing medical education are problems demanding solutions, and when bedside clinical training for medical students is about to become a problem for our general hospitals to cope with, it is heartening to see that one single solution has already been worked out for coping with all of these problems simultaneously.

For the past five years, St. Francis Hospital has been developing and polishing a program of Team Care for private patients, which has proved in

practice to be acceptable to patients, house staff, private physicians, and the hospital.

It is worth your time to sit down and read how this program has evolved, and what it is now able to accomplish. Chances are you will want to become involved with it yourself, either there or in your own hospital.

Two features of Team Care as practiced at St. Francis deserve special note: *any* doctor's patient is acceptable on the team service, which makes for a better assortment of cases and better participation; and the participants make rounds on *every* patient, not just on their own patients. Everybody seems to like it!

HARRY L. ARNOLD, JR., M.D.

The Value of the HMA-Payne Study

The "quality of medical care" in theory should be readily measured, but in reality is more difficult than expected. The HMA first initiated an attempt to define and assess quality medical care in 1967. Following the initial feasibility study by Dr. Paul Sanazarro in 1968, the recommended voluntary self assessment of our state medical society was undertaken. A study was conducted and it is unique in several respects—it is the first statewide attempt to assess quality medical care on both ambulatory and hospital patients ever to be undertaken in our nation. This study, now known as the HMA-Payne Study of personal medical quality, has been completed.

Dr. Payne, the principal investigator, has attempted to assess quality medical care by evaluating the process of medical care, and to a lesser extent, the outcome of medical care. His methods as originally conceived, and his results are to be commended for their excellent scientific effort in making this difficult study significant and precise. An HMA *ad hoc* committee studied the results of the available HMA-Payne report on THE EPI-
SODE OF ILLNESS STUDY and THE OFFICE
CARE STUDY, and concluded the following:

1. That by measurement of the *process* of medical care (documentation), it would appear that the physicians in Hawaii did not do well.
2. That by measurement of *outcome* in those illnesses where it was determinable, it would appear that the physicians in Hawaii did well.

3. That the measurement of the process of medical care (documentation) has no statistical significant correlation with the outcome of medical care in this study.
4. That modal physicians (specialists who characteristically care for the diagnosis studied, eg, a urologist for prostatic disease) in Hawaii measured the process of medical care (documentation) better than nonmodal physicians.
5. That the Physician Performance Index (PPI) could be better termed as a Physician Documentation Index (PDI).
6. That the HMA has yet to develop a complete measure of quality medical care.

Although the process of medical care documentation is an important part of the evaluation of the quality of medical care, there still remains other important aspects in the measurement of the quality of medical care such as outcome, patient satisfaction, physician satisfaction, management, and cost of care, that are yardsticks by which the quality of medical care must be evaluated.

The value of the HMA-Payne Study lies in revealing the complexity of accurately measuring the quality of medical care even with exemplary intents of organized medicine and with exemplary investigators. This challenge to HMA will hopefully be met through the Experimental Medical Care Review Organization (EMCRO).

WINFRED Y. LEE, M.D.

To Meet the Needs of Patients

The Hawaii Academy of General Practice recently went along with its national organization in changing its name—and possibly direction—to the Hawaii Academy of Family Physicians.

When the votes were counted, there were a few holdouts among local physicians, opting to keep the name of the organization as it had been since its inception here in 1947.

In this day of return to the “renaissance man”—now when there seems to be a trend from specialization back (or is it forward?) to generalization, will physicians also revert to being renaissance men? Will they return to caring for the whole patient—for the whole socioeconomicopsychophysiologiccoanatomical person?

Will more doctors be more things to more patients—parent, adviser, counsellor, healer, arbitrator, health teacher?

The need is there. The human system needs a generalist, not a digital computer, as its primary physician. Will the primary physicians be there to meet the needs of the patients?

A general (pardon me) family practice residency has been proposed for Hawaii, and a family practice department mentioned for the U.H. medical school. Both these endeavors are having some birthing problems. Perhaps when the needs of people are truly considered, the need for such training will be fully realized.

DORIS R. JASINSKI, M.D., M.P.H.

A Plague in Our Midst

When plagues have struck populations in the past, their effect has been to cause death without warning to random persons in a community, without respect for age, apparent previous state of health, or station in life.

There is today a plague in our country and in our state—endemic, epidemic, and curiously accepted, almost in a way that plagues and endemic disorders of the past were accepted by the populations they afflicted.

When someone close to us—a friend or relative, or the child of a friend—is struck down, we sorrow, we shake our heads and cry “Woe!” Then, we go about our daily affairs, with some kind of feeling of assurance that the plague won’t strike our homes or ourselves—we have been spared this time.

About 50,000 people, from all ages, walks of life, and conditions of health, die from this plague every year in our country. Over one hundred people—children, youths, middle-aged and oldsters—die from this plague every year in our state.

Although this plague was virtually unknown 70 years ago, it is frequently cited as having since caused death to more Americans than have all this country’s wars since the Revolution.

And yet, where is the outcry that “Something must be done!” to turn the tide against this death-dealing menace? Where are the epidemiological studies and where are the information programs to aid us in combating this maiming, crippling, lethal

disorder? They are there, but in a tiny whisper, by no means in proportion to the havoc that is caused in our lives.

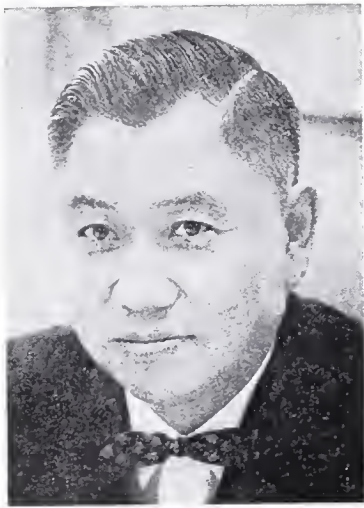
Physicians in certain specialties labor long nights and over long weekends to diminish the toll in crippling and death that this killer threatens. At times, the doctor will say, “He couldn’t be saved. This previously healthy, productive person couldn’t survive. His body was broken, his whole face was torn, his brain was too damaged.”

But, with the help of ICU, bottles containing the right ionic mixture, modern surgery, and antibiotics, many people can be resurrected after this killer has struck. To some, their lives will never be the same again—they must find other employment or take early retirement, or throw themselves on the mercy of their families or the public welfare for subsistence.

To the lucky are given a reprieve from death or serious injury—a new lease on life, in a very literal sense.

Doctor, have you done your part today in the preventive aspects of our modern plague? Are you a careful driver? Do you wear your seat harness every time you get into your car? Are you on the *qui vive* for every tailgating fool on the freeway? Are you talking to your patients, family and friends about the preventive aspects of traffic deaths and injury? Are you a good example to others?

DORIS R. JASINSKI, M.D., M.P.H.



The President's Page

It is with mixed feelings that I now turn to my last "President's Page." By the time this is in print, your new President, from the beautiful island of Maui, will be Dr. William Iaconetti, who is most capable in carrying on the duties of the President of HMA.

In the short space of a year, your Association has moved from the undertaking of a solitary project at a time, to becoming involved simultaneously with several major projects which I know are within its capabilities.

- (1) June 1971, received a grant for EMCRO for two years, totalling \$380,000, with Dr. Alex Anderson as project director.
- (2) Taken issue with the Bureau of Workmen's Compensation, with the hope of finalizing this problem under the leadership of Drs. Theodore Tomita, William Dang, and Albert Chun Hoon.
- (3) Reorganizing the internal structure of HMA along the lines suggested by the AMA. The *Ad Hoc* Committee under Dr. George Mills with past presidents, Drs. John Lowrey, B. A. Richardson, Theodore Tomita, O. D. Pinkerton, and Samuel Allison, has been meeting every Wednesday morning at 7:00 A.M.
- (4) Cooperating with the University of Hawaii in the development of the Cancer Research Center. HMA will have a large part to play in the clinical component of this project.
- (5) Applying for a grant of two million dollars to upgrade the delivery of emergency care with Dr. Livingston Wong as the Project Director. In this area, we have had the fullest cooperation from Dr. Quisenberry, Director of the Department of Health, and his assistant, Dr. Wilbur Lummis, and Dr. Thomas Chang, City & County Physician.

For the immediate, attention must be given to the development of peer review and if need be, a PSRO under you, the physicians. In this area, our expert is Dr. Winfred Lee.

Another problem to be decided is the extent of our involvement with manpower, in the medical and paramedical fields. For the present, our role probably should be one of cooperative guidance, and the focus through which groups are brought together in determining the medical education and placement of this personnel.

Many individuals have been most cooperative in the development of projects, especially Dr. M. Hasegawa of RMP, hospital administrators, Dr. Terence Rogers—Dean of the Medical School, and Mrs. Sylvia Levy of the DOH and CHP.

I am most grateful for the counsel and help I have received from my fellow officers, officers of the Honolulu County, chairmen and members of our numerous committees, and staff, in attempting to fulfill the duties of my office. My special appreciation to the House of Delegates for permitting me to appoint an assistant, first Dr. George Mills, and now, Dr. Elisabeth Anderson, and to my colleagues, Drs. William Dang, Thomas Frissell, Winfred Lee, Fred Reppun, Coolidge Wakai, and others, upon whom I have leaned so heavily during the past year.

Aloha,

Robert Y. H. Chin

Telling It Like It Is

... Merging of committees is proceeding, albeit slowly. **Water Safety** has registered no objections to merging into **Public Safety**, along with **Auto Safety and Radiation**.

... **Diabetes** agrees to function as a subcommittee of **Chronic Disease**—endorses the bi-monthly detection clinic at Queen's, is working on standardization of diabetes detection and diagnosis. May turn the Camp for Diabetic Children (held each July) over to the lay Diabetic Society and/or the YMCA.

... **Cancer**, which is a very active committee, objects to merger into **Chronic Disease**. Disapproves of Ortho's PAPette, a kit to enable women to take their own pap smear. Too few women will get a suitable smear. Voted to cooperate with American Cancer Society on Talk Force of Uterine Cancer Control, with a goal of having every woman over 20 have a Pap smear by 1976. Only *One* Pap smear? Well, I suppose that will be some improvement.

... **Health Manpower** still working on physician assistants plans. Up till now, thinking has been primarily aimed at people who have had some medical training in the military or the like, but they are now talking about training for persons just out of high school. It seems to me (based on some solid experience in backwoods medicine be-

fore specialty training), that the important steps are:

- 1) Decide what we want these people to do.
- 2) Decide what they need to know to do it.
- 3) Prepare a possible training program for untrained persons.
- 4) Devise a testing program to determine how much of 2) the nurse or ex-medie or whoever wants to be a P.A. knows, and then try to fit him into a training program to teach him the rest. Why so many years of study and gumflapping?? It's not that complicated.

... **Communicable Disease** still working on VD program. Concerned about the number of MDs who don't report cases. Do you always report?

... **Environmental Health** holding lots of meetings because of the legislature, but still hasn't worked out goals. Is solidly supporting recommendations of Udall's Overview Report, whatever that is.

... **Joint Public Relations** still working on Publicity Code. Somebody fumbled the ball on publicity, re, the Residency Requirement, the details of which seem still to be ethereal.

... **Auto Safety** working on problem of drinking driver. Dr. Bennett suggests the law should include sedatives and hallucinogenic drugs.

JOHN BROWN, M.D.

Hawaii Academy of Family Physicians



... 800 MILLION CHINESE CAN'T BE WRONG

The United States Congress is backing and filling, rather uncertainly, as it considers a national health care package. And well it might.

The much touted HMOs are not showing up well under the glare of close scrutiny. They are even being designated more clearly for what they really are: Contract Practices. The Congress is becoming aware that these are units designed primarily for cost and utilization control—as has been pointed out on this page previously—and that the quality of medical care may be compromised therefore. "Health Maintenance" Organization is definitely a misnomer. These schemes will zero in on the care of episodic illness just as much as the private practice of medicine has. That is, after all, Mr. John Q. Public's primary concern. He doesn't worry about his health when he isn't sick!

Preventicare still is a nebulous entity in terms of putting it into actual practice. In theory, it is utopian. Heretofore in practice it has been notable for being neglected. Sure and it would be nice to have every last person immunized against Mumps, Rubella, Rubeola, Polio, Diphtheria, Tetanus, Pertussis, Variola and Influenza at least. But, it cannot be done. Not in this land of the free, the independent and the stubborn individualists! Free special clinics and multiphasic screening at rock-bottom prices and complete annual physical examinations covered by all insurance carriers and health plans will cater mostly to those who are hypochondriacal over their own known chronic illnesses and disabilities. Besides, when we physicians tell our patients what they should do to preserve their own health, we are up against the insurmountable obstacle of the patient's pleasures coming first. His social demands always win out.

Consider yet another thought along the lines of health maintenance: During the recent business "recession," we have seen a concomitant, if not resultant, marked drop in hospital bed occupancy. Could this be perchance an indication that all the national clamor for greater accessibility of quality health care at cut-rate prices or subsidies is only a symptom of boredom and affluence? It seems that when pennies need to be pinched, one's so-called health "needs" tend to evaporate.

The administration in Washington may indeed be far ahead of the Congress and of the citizenry

in this. After all, it should be leading the way. We quote recent *American Medical News* comments: "There is evidence that the next major advance in the health of our citizens will come through *health education* and preventive medicine, and not necessarily through producing more doctors and building high-cost hospitals."

Did the President bring this idea back with him from Peking?

It has been interesting to note from the writings of the many visitors to China—columnists and reporters as well as physician teams—that the PRC tackled the matter of national health in a rather enlightened fashion. In order to deliver medical care to their multi-millions of population, the communist government in 1949 "embarked on a massive program of public health, with *every citizen made responsible for personal participation*," says Victor W. Sidel, M.D., in *World Medical News*, January 14, 1972. He goes on to describe a three-level system of health care on up to medical centers and sophisticated medical colleges—a system not too different from ours. However, it has a broad base of individual knowledge of self-care and the preservation of good health that is somewhat unique.

Of course, the PRC has a singleness of purpose under Mao Tse Tung that is in fact their religion. The good of the society as a whole as determined by that society brooks no individual opposition. Under such a system based on unity of purpose (we consider it a tyranny of the masses) it is understandably easy to eliminate venereal disease, for example. In our democracy based on individual freedom, it is impossible even to control VD. It is unthinkable that good health and the prevention of disease or injury should be approached in this manner, the do-good efforts of some of our influential bureaucrats to the contrary notwithstanding. We might learn some lessons, however, in how to establish a base of good public health.

From reports emanating from that still mysterious sub-continent, 800 million Chinese can't be wrong. Our best bet might be to concentrate on teaching every citizen how to preserve his own health and how to take the first steps towards solving the problems of illness or accident. The health care hunk of the national economic pie might thereby be considerably narrowed.

J. I. FREDERICK REPPUN, M.D.

Slants and Angles

HAWAII MEDICAL JOURNAL

Kahuna Corner

A resurgence of interest in witchcraft and the occult sciences precipitated the following case report which describes the "Treatment of Spinal Subdural Hematoma with Ferret's Ear" (*Punch*, February 2, 1972):

"A man, aged 59, presented with violently severe pain in the limbs and abdomen accompanied by weakness of the lower legs. A lumbar puncture yielded blood-stained fluid with xanthochromic supernatant containing 800 mg of protein and 20 mg of sugar per ml. CSF pressure was 45 mm of CSF with no rise on jugular compression. There was severe flaccid paraparesis."

"We waited until the night of the full moon and slaughtered a male ferret in rut by striking it with the femur of a defrocked sexton. We then removed its ears. The right ear was nailed to the door of Ely Cathedral as a precaution (see Treatment of Calcinosis Circumspecta with Mole Soup, *BMJ*, 1972, 2, 499), and the left ear was brought to the Orthopedic Research Unit of the Royal Camden Hospital in a teapot. It was then swung around three times."

"We drew a chalk circle on the floor of the operating theater and took our trousers off."

"The patient was then premedicated by the anesthetist who shook a beaker of dried peas over him, murmuring '*tu ne quaesieris, scire nefas*,' twice, and brought into theater (operating room). He was painted blue and the left ear of the ferret was then pushed up his right nostril at the exact stroke of midnight."

"By morning the patient was his old self again, ie, suffering from spinal subdural hematoma. In the post-clinical discussion no clear explanation emerged but the fact that the teapot had once stood on a shelf next to a garlic plant (a fact not previously known to the surgical team) was felt to be of prime significance."

Kona Winds

A long siege of hot, humid, kona weather sorely tries the equanimity of the usually cheerful and courtcous Honolulan. Traffic snarls, tempers fray and the Aloha spirit goes into a precipitous, albeit temporary, decline. Indeed, in bygone and

perhaps happier days in old Hawaii, beating one's wife at this time, while not actually condoned by the authorities was generally viewed by them as a minor matter and certainly not worthy of comment or prosecution.

Similar, denervating weather conditions affect other areas of the world—the Santana wind of Southern California and the Sharav in Israel. However, thanks to modern medicine, help may be at hand. According to Professor F. G. Sulman of the Hebrew University of Jerusalem, the tight-nerved apathy and depression carried by the desiccating desert winds of the Middle East and Southwestern U.S. can be combated.

"Headache and hot temper linked to serotonin levels elevated by high atmospheric concentrations of positive ions can be countered by serotonin inhibitors and negative ion generators. Monamine oxidase by improving utilization of depleted adrenalin counters fatigue and apathy, while the histamine-lowering thyroid depressants improve general tolerance."

All this sounds very complicated and perhaps the old Hawaiian way was simpler and just as effective.

Alaskan Trip

Alaska and Hawaii share the dubious distinction of having the highest annual incidence of new cases of tuberculosis in any of the 50 states. Fully aware of this problem, the state health authorities periodically attempt to screen the population and offer INH chemoprophylaxis to many of those with positive skin tests. Now according to Carolyn V. Brown of Anchorage, Alaska (*Lancet*, April 1, 1972) an isoniazid abuse problem has developed:

"In times, when many people are 'tripping out' on a variety of legal and illegal drugs, it may be of interest to note that another drug which has been used as a first-line defense and chemoprophylaxis against tuberculosis is also being abused. We have been aware of acute isoniazid overdose for a number of years in Alaska. Notably a large amount of this acute ingestion was by young people. Looking retrospectively at signs and symptoms we noted that a number of patients described visual hallucinations, bright colored lights and strange designs before the eyes.

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Humanistic Psychology—A Christian Interpretation

By John A. Hammes, Professor of Psychology, 203 pp., \$7.95, Grune & Stratton, 1971.

THE PREFACE for this book sets forth its principal purpose: to "present the compatibility of scientifically established psychological truth with the truths proposed by a Christian frame of reference." The text is divided into four parts entitled as follows: Basic Principles, Human Nature, Human Adjustment, and Human Destiny. While Dr. Hammes writes from a psychological viewpoint, there is nevertheless so much Christian philosophy in the book that one is not sure at times if one is reading a scientific text or a theological text. For example, some of the headings in Part 4 include chapters on "The Reality of God," "Suffering and Joy," "God and Man," "Unity with God," and "Morality, Conscience and Sexuality." I personally found the book difficult going because of the continual shifting back and forth between religion and science. I would add that the topics are not developed in any particular depth, that most of the references are religious, that the print is rather small and not easy to stay with, and that the text is sober with little relief from the seriousness.

Perhaps the thrust of the text may be summed up in the author's statement that the book has been written for college students with little or no background in philosophy or theology.

WILLIAM J. T. CODY, M.D.

American Medicine In Crisis

By Edward P. Luongo, M.D., 194 pp., \$9.95, Philosophical Library, 1971.

THIS RATHER interesting short text has as its thesis the idea that the meaning and concepts employed by present day medicine require examination within the present (day) context and in relationship to medicine's history and philosophy. The author feels that the immense accomplishments of medicine in healing the sick have been exceeded only by its willing but inadequate social commitment and that some of these inadequacies stem from nostalgic tradition and language. Part of the book is devoted to how medical heirlooms became lodged in the attic; more of it deals with the sorting through. I found Chapter Two particularly interesting with its emphasis on "Semantics in the Verbal World of Health, Disease, and Clinical Setting." Chapter Six is also intriguing: "A Semantic Analysis of Modern Psychiatry." Reading through the book was a disconcerting reminder that terms have a way of acquiring their own power and immobility and the author's relating this fact to social problems in the progress of medicine is a commendable effort.

As the author comments, much in this book is not new, "but like most writing, a synthesis of what has been said about words, ideas, and people by many other writers many other times." The book should be of special interest to educators, social workers and public health specialists.

WILLIAM J. T. CODY, M.D.

★ means highly recommended.

The Rorschach Clinician: A New Research Approach and Its Application

By Charles R. Potkay, Ph.D., 223 pp., \$11.75, Grune and Stratton, 1971.

THIS TEXT is a useful and interesting addition to the huge literature on Rorschach's inkblot test which has steadily grown over the past fifty years. It is not a beginning reader on the Rorschach method of personality assessment, but represents an expansion of a technical doctoral thesis. Clinical psychologists, psychiatrists, neurologists, and other mental health workers trained in Rorschach will find the book a meaningful if expensive extension of their work in the analysis of personality dynamics, intellectual level, cognitive style, degree of anxiety and defenses, and psychiatric diagnosis.

JAMES M. DENNY, Ph.D.

★Progress in Neurology and Psychiatry

By E. A. Spiegel, M.D., 495 pp., \$28.75, Grune & Stratton, 1970.

THIS EXCELLENT SERIES of volumes covers the fields of neurology, neurosurgery, psychiatry and the related basic sciences of neuroanatomy, neurophysiology, neuropathology and neuropharmacology. Each section attempts to serve everything written in the field. Individual articles are summarized in exceedingly pithy fashion, making for rather difficult reading. The book has an encyclopedic, ponderous tone. The bibliography following each chapter is excellent and the book in general is an outstanding source for research and for teaching purposes. However, it is much more difficult to read than the annual Year Book of Neurology and Neurosurgery which goes in the other direction and bases its review of the field on selected key articles which are reviewed from a more critical point of view. The two approaches serve different purposes and are both useful.

This series is an indispensable one for the neuroscientist in either the basic or clinical fields and should be available in every medical library.

JORDAN S. POPPER, M.D.

The T.A.T. and C.A.T. in Clinical Use, 2d Edit.

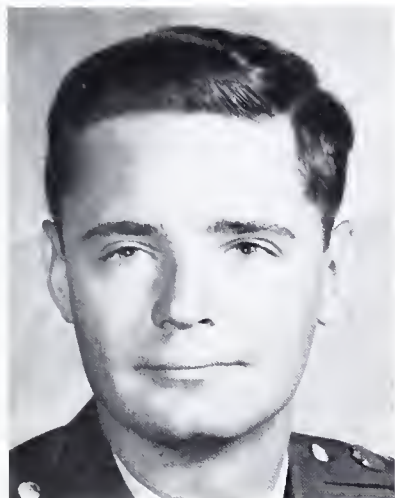
By Leopold Bellak, M.D., 338 pp., \$12.75, Grune and Stratton, 1971.

DR. BELLAK'S BOOK on the Thematic Apperception Test and the Children's Apperception Test has served exceedingly well since 1954 as a basic introductory text for these two projective tests of personality. Although the present edition represents no radical expansion or updating, beginning and advanced students of clinical psychology, psychiatry, anthropology, and social work will do well to employ it as their principal text for the C.A.T. and as a strong supplementary work for the T.A.T.

JAMES M. DENNY, Ph.D.

New Members

HAWAII MEDICAL JOURNAL



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OBSTETRICS-GYNECOLOGY

Northwestern University—1964
Internship—Highland General
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1964-65

Residency—Santa Clara Valley
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INTERNAL MEDICINE

University of Pittsburgh—1964
Internship—Providence Hospital,
Portland, Oregon—1964-65
Residency—Maine Medical Center—
1968-71



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GENERAL PRACTICE

University of Arkansas,
School of Medicine—1950
Internship—St. Joseph's Hospital,
Atlanta, Georgia—1950-51



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ANESTHESIOLOGY

Oxford University, Oxford, England—
1953

Internship—Victoria Hospital,
Swindon, England—1953-54
Residency—North Carolina Memorial
Hospital—1958-59



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PLASTIC SURGERY

Ohio State University—1962
Internship—Brooke General Hospital,
San Antonio, Texas—1962-63
Residency—Ochsner Clinic,
New Orleans, La.—1965-68
Cronin & Brauer Clinic,
Houston Texas—1968-70



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PATHOLOGY

University of Hong Kong—1965
Internship—Queen Mary Hospital,
Hong Kong—1965-66
Residency—Queen Mary Hospital—
1966-67
Queen's Medical Center—1967-69
Hahnemann Medical College &
Hospital—1969-70
Queen's Medical Center—1970-71

Tom Thorson's Corner

The following anecdote serves to warn us of handouts: A hungry sparrow, with a crippled wing, thought he had finally solved his food problem when he found a horse grazing in a pasture. . . . All was going well for him until one day he followed too close and plop! He was hit smack center by a large food packet. The sparrow struggled and struggled and finally managed to get his head above the dung heap. Too weak to extricate himself from the encompassing material, he chirped and chirped for help. A nearby cat heard the distress cries and came to the rescue. But then, after digging the sparrow free, the cat gobbled the poor bird up . . . which leads us up to the moral: *"If you're too dependent on someone, they're liable to shit all over you . . . and your rescuer is apt to eat you up."*

The last speaker on a program told the following story: A pestilence was rife in parts of Florida and quarantine stations had been set up at each countyline. A farmer had to cross several of these counties to get his supply of manure and his yardboy who had gone along to help, was riding in the back of the pickup truck with the precious cargo. As the farmer stopped at each quarantine station, he would yell to the attendant officer, "All I have in back is a load of manure and my yardboy. . . ." After listening to the same pronouncement several times, the frustrated yardboy finally pleaded with the farmer, "Hey, Boss! Do you mind introducing me first?"

A propeller driven commuter plane was readying for take off from the far side of the field. The pilot would rev up, then idle down, rev up again and idle down. After repeating this several times, the pilot started to taxi back toward the terminal. An anxious passenger asked the stewardess what was going on. The stewardess replied nonchalantly, "The pilot doesn't like the sound of the port engines so we are going back to the terminal for a new pilot before taking off."

Life in These Parts

Gary Globber, director of The Japan-Hawaii Cancer Study at Kuakini, has been collecting and checking stool specimens for occult blood. So engrossed and enthusiastic is he with the project that he has been referred to as the "Kukai Kahuna."

Our patriarch of local pediatricians, Don Marshal has worn a Medi-Alert bracelet ever since he suffered a mild anaphylactoid reaction from tasting an oral penicillin product which one of his patients found distasteful. He admitted, "I'm scared to death of penicillin and use erythromycin products whenever possible."

Fashion conscious Doris Jasinski noted at a Queen's medical conference that the uniform of the day for the house staff was blue shirts and striped yellow pants with one variation being that of yellow shirt with striped blue pants. This makes for a groovy look, what with long tresses and full beards to match. . . .

Incidentally, our editor Harry Arnold, Jr., would be happy to note that the Queen's housestaff has finally come around to using "man" and "woman" to denote the male and female homosapien species in their medical protocols. . . .

A State law revised last year made the sale of speared fish illegal. A current effort to revise the law was incorporated in a Senate Bill "Relating to Fishing with Firearms and Spears," and its advocates pointed out that

the advantage to spearing is that it is 100% selective as compared to net fishing. Quipped Senator George Mills, himself a net fisherman of some repute, and who works the reefs in front of his windward Oahu home, "I have trouble educating the mullet not to get caught in my net."

Nobu Nakasone has a talented, attractive wife, Yoshino, of whom he is justifiably proud, and who teaches the Majikina Honryu school of Okinawan dancing. We saw her stellar performance recently at the Nippon theater during festivities commemorating the U.S.'s return of Okinawa to Japan. Remembering her performances of nearly 10 years ago, when she first came over as a member of her father's troupe, we feel she has grown ever more attractive and graceful under Nobu's tutorship. . . .

Notes From the April Aetna Medicare Review Meeting

Whereas most of us berate our patients for indulging on high cholesterol foods, we do not necessarily do as we preach. Sensible John Lowrey, our neurosurgeon member, is of a different breed. We noted that he ordered green salads instead of the traditional dozen oysters on the half shell, a small broiled lean steak rather than the 16 oz. beef tenderloin, and a fruit desert in place of ice cream and pie. . . . We relate this observation simply because we are envious of his will-power and sensible eating habits. . . .

A case of generalized myalgia and arthralgia was being treated with multiple injections of xylocaine on his back and joints. The question was raised whether or not the injections should be allowed under the fee schedule. Our humorist Henry Oyama noted, "It sounds like a case of acupuncture, but the fees sound reasonable. Wonder what the prevailing charge for acupuncture is in China?"

ObGyn man Ted Tseu, in the absence of internists Gordon Liu and Bernie Fong who had gone to the Makaha/Payne sessions, was stuck with a case being treated with daily microthermy. Ted, sympathetic that the physician was trying, commented, "He tried this, he tried that . . . he tried." Again Henry Oyama rose to the occasion with his wit, "If he practices micro-therapy, perhaps he would accept micro-fees. . . ."

Again, Ted out of his field, had to discuss the case of a 81-year old man who had a TUR, bilateral vasectomy and an incidental circumcision. The question was whether or not to pay for the circumcision. Ted acquiesced, "If phimosis was in the preop diagnoses, we should allow the fee, regardless of his age."

We discovered that affable Tom Maeda's lot as a Medicare medical consultant is not an easy one. When he questioned the frequency of visits on a 73-year-old woman with ASHD, atrial fibrillation, "psycho-physiologic" cardiovascular and gastrointestinal disease, the attending physician replied sarcastically, "Prognosis poor; difficult to communicate with patient. Will gladly turn over patient to you Dr. Maeda, if you will accept." Poor Tom, he is simply following Medicare regulations. . . .

In the absence of Jerry Faulkner, our eye consultant, allergist Allan Young was assigned an eye case described somewhat mysteriously as "a filtering bleb through a cataract wound." Unable to find a proper RVS coding, Allan turned desperately to neurosurgeon John Lowrey, "Look, John, the brain is closest to the eye. Perhaps you can find a suitable code. . . ." John put brain and eye together and did.

We had to plead our own case, that of an asymptomatic man on whom we did two separate Profile III's 3 days apart. **Bernie Fong** had previously recommended disallowing the second lab test, without knowing the circumstances, so we explained, "This crazy doctor ordered two separate profiles 3 days apart," then explained how this healthy looking patient had elevated liver enzymes, so we recalled and reexamined the patient, and repeated a fasting profile. And still the liver enzymes were elevated. On a third visit, he finally revealed the information that he had been drinking 6 teacupfuls of Sake for the past 30 years. **Allan Young** came to our defense with, "It's good medicine to recheck questionable lab results," and the rest of the committee was in a friendly enough mood and chidingly decided to allow us the luxury of the repeat lab tests. So, we discovered that being on the review committee does not guarantee us immunity. Fortunately the physicians names on the cases being reviewed are always blacked out in the interest of objectivity and there is a standing invitation for disgruntled physicians to present their views to the committee and at the same time have a free gourmet dinner. . . .

Visiting Physicians

Gerald Bodey, clinical microbiology director from MD Anderson Hospital spoke on "New Drugs for Gram Negative Septicemia—Infections in Cancer Patients." Gerald, a medium statured, well-groomed lecturer with a pink cheeked youngish face and short cropped hair dresses conservatively with narrow ties and somber colored suits. Gerald prefaced his lecture with a comment about the patience and slower pace of people in Hawaii with the following story: "A Texas cowboy was noted for his patience far and wide. . . . And in Texas, that is pretty far and wide. . . . This cowboy got married and was taking his wife home in his horse and buggy. . . . Enroute, they were buffeted in the buggy when the horse stepped into a gopher hole. . . . The patient cowboy remained unruffled and simply counted, 'One.' Further along the way, the horse was frightened by a rattlesnake and again jarred the buggy and its occupants. The patient cowboy counted, 'Two' and calmly proceeded on their way again. His new bride was proud and impressed. Just as they reached their home, the horse bucked again when a rabbit crossed its path. The patient cowboy spoke softly, 'That's three,' got out of the buggy slowly, drew his gun and shot the horse dead. The amazed bride commented, 'Honey, isn't that extreme?' The patient cowpoke counted, 'That's one.'"

Herein are a few Bodey pearls:

Pseudomonas is becoming the major offender among the gram negative organisms. Polymyxin is of little benefit in *pseudomonas* because of its renal toxicity.

Gentomicin is an effective drug against a host of gram negative bacteria, but its effectiveness is affected by neutropenia, and it is also nephrotoxic, the toxicity being cumulative and dose related.

Carbenicillin, is not affected by host neutropenia and is very effective against proteus.

re, *in vitro* testing: Our methods have a lot to be desired. We do not pay much attention to *in vitro* studies especially in neutropenic patients.

re, resistant strains: There are always prophets of gloom, but the reports of seizures and resistance are associated with suboptimal doses. . . .

re, optimal therapy for gram negative infections: with normal host mechanisms, use carbenicillin with gentomicin or carbenicillin with Keflin; with poor host mechanisms, ie, with neutropenia, use carbenicillin with Keflin, and with renal impairment, carbenicillin with Keflin.

re, penicillin reactions: give antihistamines and steroids together. Antihistamines suppress anaphylaxis and while steroids do not prevent anaphylaxis, they do suppress the serum sickness type reaction.

The visiting pediatric professor at Children's for April was **Starkey Davis**, a tall, athletic type, with burnished copper hair cut fairly long and with side burns to boot, who lectured with a high pitched southern twang. **Hiro Tottori** felt that Starkey was "now located in the mid-west somewhere, but is obviously from the south." In reviewing the guidelines for common infections, Starkey recommends doing transtracheal aspirations for pneumonias, a complication of the procedure being emphysema. Another technique recommended was lung punctures, whereupon pediatric surgeon **Walton Shim** facetiously jotted down on his name card: "Do more lung punctures! In case of pneumothorax, please call me."

re, the NBT Test used in the differential diagnosis of bacterial vs viral infections: "This test is being used for everything except contraception."

AMA-ERF Benefit

The Maui-Kauai Rooms of the Waikiki Sheraton were filled to capacity with the 400 plus crowd attending the ever popular annual AMA-ERF Benefit put on by the hardworking HCMS's Woman's Auxiliary. Perhaps **Larry Gordon** best characterized the affair with the following limerick: "From noodles to strudels; And Mahu's to Madrigals" (for the sumptuous 7-course Chinese dinner was topped off with strudels of all things, instead of the usual fortune cookies, and for entertainment, "gals" from the Glades performed their song and dance numbers followed by the more accomplished Kailua Madrigals).

The usual excitement and hilarity pervaded the elbow room only mezzanine; what with silent auctions, bake sales, international pupus etc. Then, there was that preposterous lining up for cocktails where a lone bartender methodically mixed drinks while patrons thirsted. . . . But all this was forgotten when we were herded into the dining area and treated to the Iolani string ensemble. **George Kimura** apologized, bless his legal heart, and wondered why he, a lawyer handling malpractice suits against doctors, was asked to MC the affair. He wondered if someone would be tempted to do a procto on him, rather than listen to his crude jokes. . . . What with the poor acoustics, compounded by the ceiling loud speakers we missed most of his jokes, but we did manage to reconstruct a few through the courtesy of our tennis compadres, **Ben Tom**, **George Suzuki** and **Charley Ching** who apparently sat closer to the stage. . . . Herein are a few reconstructions:

The judge at a divorce hearing asked the plaintiff: "Was your husband hostile?" Marie from Pupukea was far from bright, but she minced no words as she replied, "Hoss style, dog style, every kind style, your honor."

A bumpkin from the Bayou took his new bride to the city on their honeymoon. He had himself never been out of the Bayou, but wanted to impress her with his knowledge of city ways. They came to a store advertising "Films for sale." "Honey," asked his timorous bride, "What's a film?" "Well, that's like toilet tissue," he replied with assurance. The sweet innocent thing not wanting to pass up a sale went into the store to make a purchase . . . but soon came out redfaced and indignant. . . . "I want that clerk in there arrested," she demanded. . . . "I asked about the sale and he wanted to know what size my Brownie was. . . ."

A dumb Pollak went into a bar, and didn't know how to order a drink so he carefully observed as others ordered. . . . One fellow asked for "SS" and the bartender gave him scotch and soda. Another asked for "WW" and the bartender served whiskey-water. Aha, surmised the Pollak, it's simple when you know how. . . . So, hoping to order Seagrams and 7-Up, he moseyed up to the bartender and boldly ordered, "Let me have 'Fifteen'" (For the benefit of other Pollaks like us, 7 plus 7 is not 15).

During a radio quiz program, a panel, including a Frenchman, were asked, "Now for \$16,000 please answer

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County Society News

HAWAII MEDICAL JOURNAL

Honolulu

The April 4 meeting was called to order by President Winfred Lee. He welcomed and introduced to the membership new member Dr. John W. Pearson.

The minutes of the March 7, 1972 meeting were approved as read by Dr. Chun Hoon.

A plaque was presented to Dr. Truett Bennett in recognition of his services in the AMA's Volunteer Physicians for Vietnam Program. It was mentioned that this was Dr. Bennett's third tour under this program.

Dr. K. S. Tom announced the death of Dr. Donn Grininger who died in Honolulu on March 9, 1972. A moment of silence was observed by the membership in his memory.

Guest speaker for the evening was Mr. Dennis Wong, Associate Vice President of Dean Witter & Company. Mr. Wong spoke on "Investment Strategy in a Bull Market" and matters pertaining to investment planning.

Dr. Lee reported that a special Board of Governors meeting was held for the purpose of reviewing the *ad hoc* committee's report and recommendations on the AMA's Invitational Study of the HMA. He stated that the Board discussed the report, suggested some changes and approved the committee's recommendations as amended. Dr. Lee brought out that under the section pertaining to the amalgamation of the HMA and HCMS, the AMA had recommended that the HMA should be the dominant organization. Our *ad hoc* committee made a change and recommended that the HMA should be the dominant policy making organization for statewide programs. The committee did not agree with the AMA's recommendations 4, 5, 6 and 7 concerning the disposition of the County Society under this new setup, and the Board of Governors felt that this matter should be presented to the general membership for discussion. Dr. Lee read the recommendations in question. In essence they recommended that the HCMS be divided or districted into several satellite societies, or as an alternate approach, eliminate the HCMS entirely, and have all functions and services provided by the State Association. Dr. Lee summarized briefly arguments for maintaining the present structure. He stated that instead of dividing the society into districts or groups which could increase administrative costs and dues, we should become more responsive to the members needs and make the county stronger. He stated that the *ad hoc* committee's report will be presented to the HMA Task Force whose report and recommendations will be submitted to the House of Delegates for final action. The membership had no comments to make.

Dr. Lee reported on the officers and staff's visits to the clinics, groups, and hospitals. He stated that visitations have begun and it has been the general feeling that these meetings have been beneficial to both sides. Hopefully the input received from the members contacted will furnish us with some guidelines as to what would be the best way to effect changes in the bylaws to make the Society more viable and more responsive to the membership's needs. Dr. Lee informed the membership that they could become involved and give input into the Society by attending membership meetings, by contact with members of the Board of Governors who is our governing body, and by filling out the AMA membership opinion poll and questionnaire that was sent to every physician.

The March 7, 1972 meeting was called to order by President Winfred Lee. He welcomed and introduced to the membership new members: Drs. Lina Lai Ying Yu, Robert C. Allin, and James H. Penoff.

Minutes of the February 1, 1972 membership meeting were approved as read by Dr. William Moore.

It was announced that a film strip dealing with the legal, financial, and insurance problems involved in operating a business as a partnership or close corporation was available to anyone interested in viewing it. Also available from Edward C. Barnett and Associates are the services of a consultant to answer questions.

Mrs. Frederick Shepard announced that the Auxiliary's annual fund raising AMA-ERF Benefit will be held April 15 at the Waikiki Sheraton. A Chinese dinner will be preceded by a handcraft sale and auction. Tables of ten are available at \$12.50 per person.

Dr. Lee requested of the membership that all questions directed to the speaker on the program be put into writing and pieces of paper were passed out for this purpose.

Dr. Francis Oda introduced the speaker for the evening who was Mr. Robert K. Hasegawa, Director of the Department of Labor and Industrial Relations. Mr. Hasegawa discussed problems of mutual interest and concern in the administration of the Workmen's Compensation Law and Fee Schedule. Questions and answers followed his presentation.

Dr. Lee announced that the posters for physicians' offices required by the Phase II Guidelines will be found in the form of a tear sheet from the AMA Journal and that such a sign with appropriate wording is also available from the Society office upon request.

Hawaii

A regular meeting of the Hawaii County Medical Society was held on March 16, 1972, at the Hilo Hotel.

Doctors present included: Carvalho, Mitchell, Woo, Brown, Matsuura, Jones, Hesterly, Helms, Tomoguchi, Lundborg, Casile, Bracher, Ballerini, Nagashima, Caldwell, Steuermann, and Adams.

The meeting was a combined meeting of the Hawaii County Medical Society and the Hawaii County Bar Association. Lawyers in attendance were: Bob Bethea, Valta Crook, Tom Leuteneker, Bob Jinks, Mike Medeiros, Bill Chillingworth, Roy Nakamoto, Terrence Yoshioka, Ben Gaddis, Clifford Lum, George Yuda, Duane Carlsmith, and Molly Zimring.

The business portion of the meeting was held first and the following physicians were approved as new members of the Society: Alexander S. K. Miles, Arch Thomas Wigle, and Richard Lundborg.

The principal speaker was Mr. Robert Bethea, who is given substantial credit for drafting the rules and regulations for a joint medical and legal advisory panel whose purposes would be to: 1) Discourage malpractice cases without foundation, 2) Encourage settlement of malpractice cases with foundation, 3) Screen medical malpractice cases. The plan which he presented was voted on and approved by both the physicians and lawyers present. It was decided that the president will designate three physicians to be on the panel. The first physician will be designated to serve for one year, the second physician for two years and the third physician for three years. Each year a new member will be elected.

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Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

March 17, 1972—5:00 P.M.

Mabel Smyth Conference Room

PRESENT

Dr. Herbert Y. H. Chinn presiding; Drs. William Iaconetti, John Lowrey, R. Varian Sloan, Thomas Frissell, George Mills, William Dang, Grover Batten, H. William Goebert, Jr. Peter Kim, Ed Helms, Sakae Uehara, George Goto, Cesar deJesus, Winfred Lee, Calvin Sia, Coolidge Wakai, Charles Judd, J. I. F. Reppun, DeWitt Smith, Denis Fu, Katok Chuang, and Rowlin Lichter. Others were Walter Quisenberry, Livingston Wong, Judd McNamara, Mor McCarthy, Edmund Lum, Masato Hasegawa, Robert Worth, and Elisabeth Anderson; plus Messrs. V. Thomas Rice, Tom Thorson, Tom Leineweber, and Jon Won.

CALL TO ORDER

The meeting was called to order by President Chinn.

MINUTES

Minutes of the February 25, 1972 meeting were reviewed. Motion was made, seconded, and passed to accept the minutes as circulated.

COMMUNICATIONS NOT REQUIRING ACTION

A letter from Dr. Carl Lum, President of the Hawaiian Surgical Association, requesting that their Association be called upon to serve as consultants in all activities related to the practice of surgery, to be a participant in negotiations regarding fees, and to assist in programs designed for the betterment of surgical standards in our hospitals. Copies of the letter were given to Dr. Maurice Nicholson, chairman of the Fee Survey Committee, and to Dr. Winfred Lee, President of the Honolulu County Medical Society.

COMMUNICATIONS REQUIRING ACTION

A. A letter was received from Dr. Robert Worth, U.H. Research Corporation, requesting endorsement of evaluation and quality of care given DSS clients in the Kaiser-DSS experimental contract. Dr. Worth was present at this meeting to discuss the study with the Council. It was pointed out that the EMCRO Study is still experimental, its purpose being to establish reliable criteria for estimating optimum quality of care in given conditions for use in forming baselines for ongoing professional medical education. In this respect, it was thought premature to use these criteria as a means of comparing quality of care.

ACTION:

It was moved, seconded, and passed "that the President be directed to send a letter in which he states that the criteria which Dr. Worth requests are in the process of being developed and that the data are premature and that, therefore, the information requested cannot be made available."

B. A letter was received from Dr. Terence Rogers inquiring whether it would be a good idea for the Medical School Executive Committee and the Council of the HMA to hold regular conjoint meetings for the purpose of exploring new policies and ironing out difficulties. As clinical teaching programs are developed in the hospitals, full time faculty of the Medical School undoubtedly will become more involved with practicing physicians. Dr.

Rogers suggested monthly or quarterly meetings for a start with alternate chairmanship at these meetings. Members of the Council felt that these meetings should be held with HMA officers, instead of the Council, every three months or on call. It was decided that the President will write a letter to Dr. Rogers that the HMA officers would be glad to meet with the Medical School Executive Committee.

C. A letter was received from Dr. Raymond Tamura relative to the statistical approach to the matter of determining fee studies and levels of changes in the practice of medicine.

ACTION:

Motion was made, seconded, and passed that "the matter be referred to Dr. Elisabeth Anderson for further study and to have it referred to the appropriate committee which shall report back to the Council."

REPORT OF THE SECRETARY

The Secretary's Report was reviewed and filed as submitted.

REPORT OF THE TREASURER

The Treasurer's Report was reviewed. Dr. Frissell pointed out that the \$1,500 for Miss Lee McCaslin's membership with the Oahu Country Club still appears as an asset in the Suspense Account. Miss McCaslin had been notified by the Council in a letter dated August 3, 1970 that it was the opinion of the HMA Legal Counsel that the amount paid to the Oahu Country Club was an advance for her benefit and as such it should be refunded to the Association. The subject was referred to the HMA officers for action. The Treasurer's Report was filed subject to audit.

REPORTS FROM THE COMMISSIONS AND SPECIAL COMMITTEES

A. *Committee on Commissions:* Dr. Winfred Lee presented a report on the proposed changes to the Association's committee structure. The proposal established seven commissions, one more than the six now existing; however, many committees were combined under one heading, some were absorbed by other committees with related functions, and still others were transferred to another commission where deemed more appropriate, which resulted in fewer committees under seven commissions. Dr. Lee's recommendations for implementation of his proposal were accepted with some modifications:

- (1) That the above proposed committee structure for HMA be accepted in whole or as amended and be presented to the House of Delegates for their approval.
- (2) That these recommendations be referred to the Bylaws and Parliamentary Committee for rewording to be presented to the next House of Delegates.
- (3) That the Committee on Commissions prepare goals and functions for the above proposed committee structure, and that this to be presented to the next House of Delegates for approval.

B. *Commission on Interprofessional and Public Affairs*

1. The TV-Radio Committee requested a supplemental budget for the balance of 1972 to carry on its weekly television program "HMA Hotline" which has been televised on KGMB since March 12th.

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HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION CHONG, *Board of Directors:* NELLIE CHANG, WALTER HARANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, WILFRED OGOMORI and BETTY BELL.

"Third Party Prepaid Prescription Programs"

A report, "Third Party Prepaid Prescription Programs," of the Subcommittee on Environmental Problems Affecting Small Business to the Select Committee on Small Business, House of Representatives, 92nd Congress, is worth our attention. The report recommends reinterpretation of the Sherman antitrust act to allow permissible consultation of insurance plan administrators with representatives of groups of independent pharmacists in matters affecting professional fees and pharmacy costs.

The conclusions and recommendations of the subcommittee are reprinted here for your perusal.

Conclusions

The subcommittee is of the opinion that the position of independent retail pharmacies may rapidly deteriorate under the present development and implementation of prepaid prescription programs.

While prepaid prescription programs are a relatively new phenomenon, the impact of which is impossible to fully assess at this time, the subcommittee concludes that many present practices employed in administering them are unduly onerous and, in particular, that by their very nature, they involve an imbalance of power between plan carriers and individual druggists which is especially serious in the case of independent small business pharmacists.

Of particular concern to the subcommittee in this connection is the present interpretation of the antitrust laws which permits program sponsors and administrators jointly to determine pharmacy fees and contract terms and conditions, while prohibiting independent pharmacies, which are most affected by such programs, from having any collective voice in the development of such plans. The independent pharmacy is, therefore, subject to the demands and dictates of third parties who may not appreciate and understand the particular problems of small business.

The subcommittee is of the opinion that the present situation must be altered in the immediate future to protect this vital sector of the small business community. The subcommittee feels that such changes can be made without adverse effects on consumers on program sponsors and administrators.

As a result of the pharmacists' inability to collectively negotiate with program administrators, a multitude of problems has surfaced.

In some areas, fixed fees are inadequate and require a pharmacist to absorb the sales tax. The method of determining acquisition costs, in some instances, may dampen a pharmacist's initiative to purchase drugs at the lowest wholesale price. Some plans are entirely too slow in reimbursing a participating pharmacy and may require administrative procedures greatly out of proportion to practical and realistic requirements.

The subcommittee is of the opinion that prepaid prescription programs may be a decisive factor in the future existence of independent pharmacies. It is important that these problems be recognized and adequately dealt with at this early stage in the development of such programs.

Program administrators and sponsors are to be commended for developing and initiating an ingenious concept to assist the Nation's health care needs. The subcommittee is cognizant of plan administrators' efforts to cooperate with independent pharmacies and of the fact that some problems will be solved in due course of time. However, in spite of commendable efforts by administrators and sponsors, independent pharmacies are experiencing severe problems due to circumstances beyond their control, and in some instances beyond the control of administrators and sponsors. These problems must be acknowledged by all concerned and appropriate action taken to assure an equitable participation in these programs by independent pharmacists.

Recommendations

The recommendations of the subcommittee are as follows:

1. That program administrators—usually insurance companies—and representatives of affected Federal agencies meet with representative groups of independent pharmacists for the purpose of developing a uniform claim form, thereby eliminating time-consuming paperwork now required of druggists.

2. That the administrative procedures of prepaid prescription programs be reexamined with a view to cutting redtape to a minimum.

3. That the professional fee to be paid to pharmacists compounding prepaid prescriptions be flexible and based on variable factors rather than rigid and inflexible.

4. That program sponsors and administrators revise their procedures for reimbursement so that participating pharmacies can receive prompt reimbursement for prepaid prescriptions.

5. That, to insure that the operation of third party plans is equitable to all parties—pharmacists, program sponsors and consumers—the Federal Trade Commission in consultation with the Department of Justice, Department of Health, Education, and Welfare, the public, insurance carriers, and pharmacy representatives, develop antitrust guidelines implementing a system of consultation between pharmacy representatives and plan administrators. Keeping in mind the narrow line between permissible consultation and prohibited negotiation, such consultation should include matters affecting professional fees and pharmacy costs.

6. That this committee be advised by appropriate parties no later than February 1, 1972, on action taken in connection with this report and the recommendations of the subcommittee.

What are the Real Issues facing the profession of Pharmacy . . . are we listening to the demands of the consumer?

I predict that by the end of 1971 one-third of this nation's population will have their prescriptions paid for through some kind of third party mechanism . . . public

or private. By 1974 we shall have a national health care insurance program meeting both the medical and pharmaceutical needs of all the people in this great nation.

Will the national health care system be established on pharmaceutical service parameters developed by the profession? Probably not unless we are willing to take a good look at our existing pharmaceutical delivery system, its strengths and weaknesses . . . today! Yes, many communities have accessible, quality pharmaceutical services, but others have none or just minimal services. We have an informalized pharmaceutical delivery system assembled piecemeal on economic considerations rather than on accessibility or level of professional services required by a community. Do we have the courage to acknowledge our weaknesses and to assume a meaningful leadership posture for pharmacy in the development of our role in the national health care system? Yes, we do!

First we must listen . . . listen carefully to the consumer . . . he wants comprehensive, accessible medical and pharmaceutical coverage at a predictable cost. Consumers have already organized to cover their medical needs as evidenced by the United Mine Workers and other labor-management health centers. We must react to these consumer pressures in the planning and development of all health care delivery systems of which pharmaceutical services are an integral part.

Second, we must define quantitatively the term quality pharmaceutical services. What do we consider a minimal standard of professional licensure? Maintenance of patient record cards? (They're really of no value unless the pharmacist uses his knowledge to prevent drug interactions and avoidable allergenic reactions, etc.) Compulsory continuing education? Around the clock emergency service?

Third, once we've critically examined the elements of our professional practice and determined the minimal essentials of all pharmaceutical licensure, we must set up a mechanism of peer review to mirror our performance relative to documentation of services, medication given, appropriateness of utilization, reasonableness of charges, and to provide a continuing education experience for participating pharmacists. The National Pharmacy Insurance Council would call such a group a Pharmacy Service Evaluation Committee (PSEC). Our medical colleagues in Hawaii are a step ahead in their effort to establish standards of medical care via their current Experimental Medical Care Review Organization (EMCRO). Funded by the Regional Medical Program, the Hawaii Medical Association is working with their membership to develop criteria for the care of specific disease entities and furthermore to delve into the adequacy of the documentation of patient records in the hospital as well as in the office setting. Organized medicine in Hawaii has taken a giant step toward maintenance of the voluntary system in medical care delivery via "EMCRO." I would hope organized pharmacy might emulate their lead with an adjunct pharmaceutical review.

One of the recommended solutions to the clamor of the public for accessible, comprehensive range of medical services at a predictable cost is the Health Maintenance Organization, HMO.

The HMO is based on four principles:

... It is an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of

... an agreed upon set of comprehensive health maintenance and treatment services for

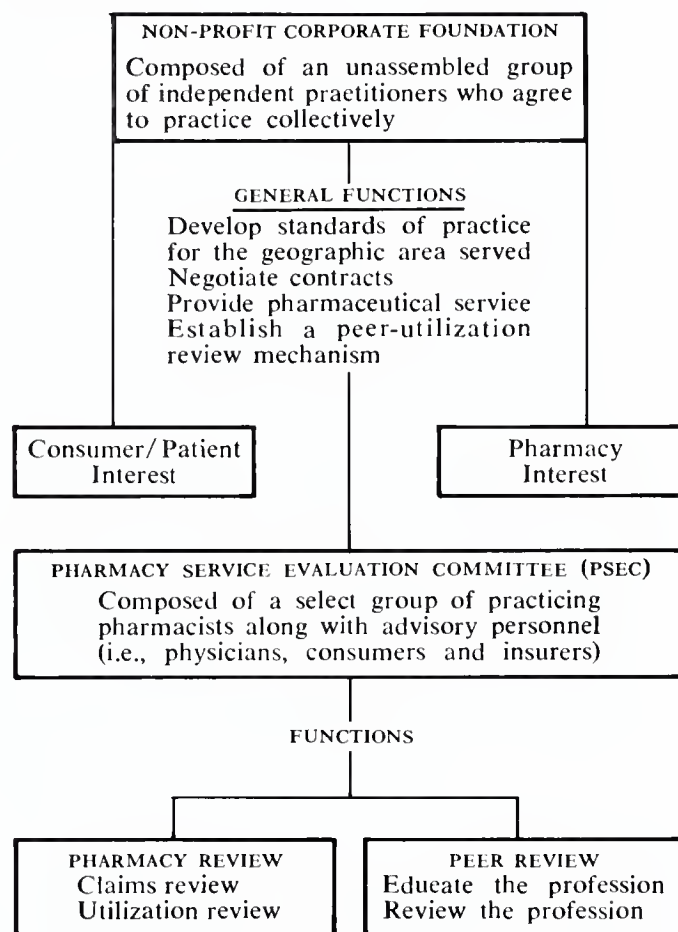
... a voluntarily enrolled group of persons in a geographic area and

... is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

The HMO can be organized and sponsored by either a medical foundation, community groups, governmental unit, etc. The group making available the services of physicians, pharmacists, and other health professionals on an inpatient or outpatient basis via the "one stop" health care delivery concept.

How can the pharmacist participate in the HMO retaining his right to independent practice while insuring the patient's right to free choice of pharmacy? In California the medical profession has found the non-profit corporate foundation a meaningful vehicle for the distribution of medical services to organized consumer or governmental groups. There are now some 36 active foundations in California. They do not serve as an insurance company but act as a catalyst for medical programs, setting fee schedules and medical care standards, which if incorporated in to insurance programs will be accepted as full payment by the participating physicians.

The National Pharmacy Insurance Council recommends this same foundation prototype for pharmacy group practice participation in the Health Maintenance Organization.



Pharmacists in the community must first relate to each other and form a foundation and secondly, they must also relate to the physicians and other prescribers in the area to establish a workable and effective drug utilization review mechanism.

The National Pharmacy Insurance suggests specific Standards of Pharmaceutical Service as abstracted below.

1. All pharmaceutical services provided to the patient are the responsibility of the pharmacist and shall be under his supervision and control; i.e., certification of the prescription order, possible pharmaceutical incompatibilities, etc.
2. Certification of the finished prescription.
3. Issuing of the prescription medication to the patient personally assuring himself that the patient understands precisely how to use the medication to achieve his physician's optimal treatment goal.
4. All medications on prescription (whether legend or non-legend) shall entail the same level of pharmaceutical service.
5. The patient should always have the right to select the pharmacy of his choice.

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ACTION:

Motion was made, seconded, and passed "that this request be referred to the Finance Committee for further review and possible eventual decision."

2. The Public Relations Committee submitted a list of recommendations for initiation rites to be used at an annual ceremony for new members of the State Association and county societies.

ACTION:

Motion was made, seconded, and passed "that the subject be tabled until we are able to talk about it."

3. The Health Manpower Committee, through its chairman Dr. H. H. Chun, recommended that HMA endorse a concept that the practicing medical community play a major role in the education and certification of new medical manpower.

ACTION:

Motion was made, seconded, and passed "that we accept Dr. Chun's recommendation."

C. Commission on Internal Affairs

Annual Meeting: A preliminary program for the Annual Meeting was presented. A few minor changes will be made on the official program. It was reported that only a few booths are still unsold out of a possible 49 booths allocated. Close to \$5,000 have been received from pharmaceutical companies and health agencies to be used to cover expenses for the scientific portion of the meeting. The House of Delegates will again meet on Tuesday and Thursday afternoons.

The Arrangements Committee has been busy planning the social and sports programs. The banquet is to be held on Friday night, May 12, at the Ilikai Hotel. The Woman's Auxiliary will hold their Annual Meeting and luncheon at the Sheraton-Waikiki on Friday, May 12. Sportsmen's Night Party will be at the Natsunoya Tea House on Saturday, May 13. The different sports tournaments include golf, tennis, bow and arrow hunting, skin diving, and fishing. Because two golf trophies have been retired, two new trophies will be put up—one for low net and the other for low gross. Funds will be solicited from HMA members who participate in the golf tournament for the John Felix Memorial Trophy, and Hilo physicians will be handling funds for the Robert Miyamoto Memorial Trophy.

The A. H. Robins Award for Community Service will be presented at the banquet. Journalism awards for professional and educational divisions for medical writing will also be presented at the banquet.

D. Commission on Public Health

1. Environmental Health Committee's chairman, Dr. Leigh Sakamaki, requested travel funds to attend the AMA Council on Environmental Health and Public Health the latter part of April in Los Angeles.

ACTION:

Motion was made, seconded, and passed "that Dr. Sakamaki be permitted to travel to Los Angeles on HMA expense, and that he be requested to submit a report of his trip to the Council."

2. The Communicable Disease and Immunization Committee recommended that HMA participate in the "Comprehensive Program to Combat Venereal Disease."

ACTION:

Motion was made, seconded, and passed "to approve the recommendations."

3. School Health: Dr. Sia reported on the Three-on-Two Program of the Department of Education and requested HMA approval in presenting testimony at a public hearing on the Program before the House Educa-

tion Committee. Dr. Sia pointed out that the Three-on-Two Program has areas of success and benefits many of the children in Hawaii, but that there is still a strong need to have one or two structured classrooms for children with some form of learning problems especially in the formative years.

ACTION:

Motion was made, seconded, and passed "to approve Dr. Sia's request."

4. The Ad Hoc Committee on Drug Abuse recommended that the HMA does not endorse the drug abuse booklet entitled "Guidelines to the Perplexed." It was reported that there are certain flaws in the booklet which should not be endorsed by the Association.

ACTION:

Motion was made, seconded, and passed "that we give approval of the recommendation that HMA does not endorse the booklet."

UNFINISHED BUSINESS

A. Emergency Medical Service System in Hawaii: This proposed project is to be sponsored by the HMA to establish a Statewide Emergency Medical Service System in Hawaii by upgrading ambulances, training personnel, upgrading hospital emergency medical service, establishing a trauma center, developing communications, legislation, public education and quality evaluation. The proposed project period is four years.

ACTION:

Motion was made, seconded, and passed "that HMA prepare and submit an emergency medical care system proposal with HMA as grantee to RMP and/or other sources."

ACTION:

Motion was made, seconded, and passed "that HMA support SB 1613 and SB 1614." These bills relate to mobile intensive care paramedics. Dr. Quisenberry answered Dr. Chinn's query that the Department of Health gives approval of these bills."

B. 1971 Resolution on Osteopaths: The 1971 House of Delegates passed Resolution #4 requesting that the HMA propose necessary changes to allow osteopaths membership in HMA and to propose qualifications for membership of osteopathic physicians. These proposals were to be brought before the 1972 House of Delegates for consideration. After some discussion the following action was taken:

ACTION:

Motion was made, seconded, and passed "that the Maui delegation instruct the Bylaws Committee to propose necessary changes to allow membership and to propose qualifications for membership of osteopathic physicians."

C. Report of the last EMCRO Meeting: Dr. Winfred Lee reported that the criteria for EMCRO is experimental and that as such its data cannot be disseminated to everyone.

ACTION:

Motion was made, seconded, and passed "that HMA reiterate that EMCRO is a project of the HMA, and that the final decisions on all EMCRO dispositions, findings and data must be approved by the HMA as provided in the contract with Dr. Alexander Anderson."

D. Report from the "Blue Ribbon Committee:" Dr. Mills reported that this committee met regularly since January to study the overall HMA structure and the consolidation of HMA and HCMS activities using guidelines submitted by the AMA Evaluation Study. It is this committee's positive feeling that the present system should be modified. A recommendation will be submitted to the House of Delegates.

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Will his return to work mean the return of undue psychic tension?



When it's mandatory to keep the post-coronary patient calm, consider Valium (diazepam).

Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. If he experiences excessive anxiety and tension because of overreaction to stress, your prescription for Valium can bring relief. During the period of readjustment Valium can quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

Valium® (diazepam)

For the tense cardiac patient who must be kept calm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg *b.i.d.* to *q.i.d.*; alcoholism, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d.* *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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NEW BUSINESS

A. Report on AMPAC: Mr. Thorson reported on the AMPAC Conference which he attended in Washington, D.C., in March. Among many topics discussed were new legislation affecting PAC organizations relative to campaign spending and the reporting by candidates and committees who are giving financial support to candidates. Professional corporations cannot contribute dollars or services. Doctors who are incorporated must be alerted to this, since, if they wish to make a contribution to a candidate, they must do so as an individual and not through their professional corporations. Corporations such as medical societies may set up separate organizations such as HAMPAC for political purposes although they must report their organizational structure. Regarding the PAC organization in the State, it is highly recommended that the PAC Board consist of members from the Woman's Auxiliary and various political subdivisions of the State. Because of changes in the law, it is now possible to lend staff support from the State Medical Associations to PAC operations. It is also strongly recommended that the State PAC report to the annual meeting of the Medical Association.

B. Health Planning: Mr. Won reported for the information of the Council that there are at least six agencies that are involved in community health planning. The Council should be aware of this activity as it affects most physicians in the State, and, therefore, the HMA and the physicians should be alerted.

C. Dept. of Social Services: It was pointed out that the Association wrote a letter to DSS some years back stating that the HMA accepted a conversion factor of five. If a subsequent letter has not been sent, then a correcting letter should be sent reiterating that HMA's position is usual, customary and reasonable.

ACTION:

It was moved, seconded, and passed "that we reiterate that HMA be on a usual, customary and reasonable fee."

ADJOURNMENT

The meeting was adjourned at 11:30 p.m.

R. VARIAN SLOAN, M.D.
Secretary

BUDGET COUNCIL MEETING

April 14, 1972—5:00 P.M.

Mabel Smyth Conference Room

PRESENT

Dr. Herbert Y. H. Chinn, presiding; Drs. William Iaconetti, John J. Lowrey, R. Varian Sloan, Thomas Frissell, William W. L. Dang, Grover H. Batten, H. William Goebert, Peter Kim, Ed Helms, Sakae Uehara, George Goto, Cesar deJesus, Winfred Y. Lee, Calvin C. J. Sia, J. I. F. Reppun, Denis Fu, Katok Chuang, and Wilbur Lummis plus Beverly C. Payne. Others present were Mrs. Sydney Fujita, Messrs. V. Thomas Rice, Tom Thorson, Tom Leineweber, and Jon Won.

CALL TO ORDER

The meeting was called to order by President Chinn.

MINUTES

Minutes of the March 17, 1972 meeting were reviewed and approved as circulated.

REPORT ON THE QUALITY OF CARE STUDY

Dr. Beverly Payne reported on the seminars presently being held at Makaha. These seminars are a result of the second data collection period in the Quality of Care Study. Copies of the Episode of Illness Study and Office Care Study have already been received and a third report is expected in 1973.

ACTION:

It was voted that the President-elect be empowered to select a committee to review the Episode of Illness and Office Care Studies and make their recommendations to the Council or House of Delegates.

Permission was given by Kuakini Hospital to HMA representatives who were interested in attending the last seminar at Makaha. President-elect Iaconetti asked that Drs. Winfred Lee and Fred Reppun attend the seminar and that they and Dr. George Goto serve on the above-mentioned committee.

COMMUNICATIONS REQUIRING ACTION

A. Letter from Dr. Alexander Anderson regarding use of EMCRO criteria for Cervical Strain.

ACTION:

It was voted to approve the use of the EMCRO criteria for cervical strain.

B. Invitation to attend HMSA Annual Meeting.

ACTION:

Either the President or President-elect will attend the meeting.

C. Watumull Fund for the Medical School.

ACTION:

It was voted to ask the Watumull Fund to again appropriate scholarship monies for University of Hawaii Medical students.

REPORTS FROM THE COMMISSIONERS AND SPECIAL COMMITTEES

A. Committee on Commissions: Permission was given to the Council by the 1971 House of Delegates to reorganize the present committee structure on an experimental basis. Rather than request a change in Bylaws at the 1972 House of Delegates, it was felt the Committee on Commissions report should be implemented on a trial basis. Later this year, a special House of Delegates could be called and constitutional changes made at that time.

ACTION:

It was voted that the HMA Council be empowered to implement the report of the Committee on Commissions and establish committees on an ad hoc basis.

The Committee on Commissions report includes the present Cancer Committee with the Chronic Illness Committee. It was suggested that Cancer remain a separate committee since there will undoubtedly be increased activity in this area.

ACTION:

A motion was made that the Cancer Committee be a separate committee under the Public Health Commission. The motion failed to pass.

B. Commission on Legislation: Dr. Goto reported on the status of legislation of interest to HMA: a bill limiting actions in medical malpractice cases will probably pass; a bill allowing general medical care, but excluding surgery and abortion, to minors 14 years or older awaits the Governor's signature; a bill providing for gonorrhea examinations is very close to passage; a measure to repeal the one-year residency requirement for medical licensure was superseded by a Federal court decision; and a Workmen's Compensation bill providing for the UCR concept passed the Senate but died in the House.

ACTION:

It was voted to give Dr. George Goto a vote of thanks for his legislative work.

continued page 216

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C. Woman's Auxiliary: Mrs. Fujita expressed her appreciation to the Council for allowing her to attend the Council meetings during the past year. She noted the Auxiliary funds have been adequate and they do not anticipate an increase in their request. She urged the Council to continue to include the President of the Auxiliary at the Council meetings.

D. Annual Meeting: The theme for the 1973 Annual Meeting was presented for approval.

ACTION:

It was voted to approve "Clinical Pharmacology and Therapeutics" as the theme of the 1973 Annual Meeting.

E. Letter from AMA Study Committee: The AMA Study Committee requested that their report be presented at the House of Delegates and that a special meeting of the House of Delegates be held to fairly review and discuss many of the major decisions and changes embodied in the report.

ACTION:

It was voted to accept the recommendation of the AMA Study Committee.

UNFINISHED BUSINESS

A. Emergency Medical Service Grant: A progress report was given on the Emergency Medical Services grant request. This request, of approximately three million dollars for a four-year period, has been submitted through RMP. HMA will be the grantee with Dr. Livingston Wong as project director.

ACTION:

It was voted to approve the Emergency Medical Service project of HMA. Dr. Goebert abstained.

B. Workmen's Compensation: Mr. Rice was asked to bring the Council up to date regarding the suit that has been filed against the Department of Labor. An appeal to the Circuit Court has been filed protesting the record of the Public Hearings. The question of a supplemental budget for 1972 to cover legal fees was discussed.

ACTION:

It was voted to recommend to the House of Delegates that the sum of \$20,000.00 be appropriated to allow Mr. Rice to proceed on the Workmen's Compensation legal suit.

NEW BUSINESS

A. Budget: The TV-Radio Committee has requested additional funds for 1972 to meet production costs for the new program on KGMB, "HMA Hotline." It may be possible to obtain funds from private foundations to continue the program for the rest of 1972 and a portion of 1973.

ACTION:

It was voted to recommend to the House of Delegates that only the funds presently budgeted for 1972 be appropriated for the TV program and that the request for 1973 be limited to \$7,500.00 and be specifically reserved for the use of the TV Committee.

Assistant to the President: This position was not budgeted during 1972 but is included in the 1973 budget.

ACTION:

It was voted to recommend an appropriation of \$12,000.00 for the position of Assistant to the

President but that the salary be subject to the approval of the President and the Executive Committee.

Grant funds: The income derived from grants was discussed as it relates to the division of staff time, etc. from the HMA-HCMS staff.

ACTION:

It was voted that the income from projects be allocated to the organization that generates it and that the costs be allocated according to the percentage of utilization.

ACTION:

It was voted to accept the 1973 budget requests with the proper changes.

B. Appointment to the Mabel Smyth Board of Directors: The Council considered the appointment of a physician to the Mabel Smyth Board.

ACTION:

It was voted to nominate Dr. Grover H. Batten as the HMA representative to the Mabel Smyth Board.

ADJOURNMENT

The Council expressed their appreciation to President Chinn for the hard work he had done during the year. President Chinn thanked the members of the Council, county presidents, and commissioners for the attendance at the council meetings and their counsel during the year.

Meeting adjourned at 10:00 P.M.

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Secretary

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where you would first kiss a woman before making love." The panelists got together and came up with the answer, "The lips." Moderator: "Correct! Now for \$32,000, please answer, where would you kiss her next?" Again the eager panelists got their heads together and came up with the answer, "The breasts." The moderator, looking at the Frenchman, "Now for \$64,000 please answer where you would kiss her next when making love." The frustrated Frenchman protested, "No sense asking me, I answered the first two questions wrong. . . ."

Between jokes, the MC introduced a Macey Williams, a rather attractive brunette from where we sat, who sang with a sultry contralto. Just another singer, we thought and paid little attention till an auxiliary member pointed out that "she" was a "he." Both Cool Wakai and Paul Tamura on our table stopped their golf shop talk and gazed unbelievably. . . .

The Madrigal Singers, we truly enjoyed. . . . And as usual, we marvelled at Shigeru Hotoke's skill in getting together his group of talented high school kids year after year, but somehow we missed The Floating Ribs, ie, Ed Kagihara's group with Jerry Tucker, Bill Hindle, and Bob Lee and some of John Smith's repertoire of drunk jokes, and of course Kathryn Murray. . . .

Our sincere thanks to Dorothy Shepard, auxiliary president, the two co-general chairmen, Irene Johnson and Dorothea Waxman and all the hardworking auxiliary members for making donating money fun. . . .

DDD Tournament

We met Bob Wong the day after the fateful DDD Tournament and asked how he did and got the rueful reply, "Too windy." Year after year, the annual Drug-gists, Dentists, and Doctors Tournament at the Francis Brown GC is a contest of nerves to see how we fare under adversity viz wind, rain and clinging red mud. . . . As we staggered into the clubhouse, Wini Lee was drowning his sorrows with his infectious happy grin and generous Joe Nishimoto was inviting everyone over to his Pearl City office for pupus, drinks and showers before venturing to the stag party at Kanraku. Francis Soon, our MD representative, was bemoaning the fact that all those he chose to represent the MD team had done poorly. But then, how was he to know that Art Salcedo would slip in his swimming pool and fracture a cervical spine the week before, and that his last minute substitute Quint Uy would shoot three birds for a gross 83 and a net 67 even with all that gusty wind, rain squalls, and the tricky greens. . . .

Among the "A" flighters, the dentists took all the low net honors and the only MD's we noticed making the cut off were Nobu Nakasone and H. Yokoyama with net 74's. This H. Yokoyama who shot a 47-39 was ecstatic about an eagle (his first in 25 years of golfing) on the easy birdie No. 17, so the first person he happily announced this to in the clubhouse was Roy Iritani who mentioned he too had an eagle the week before on the first hole. . . .

The "B" flighters cornered all the low net honors with Quint Uy winning the overall low net trophy with his remarkable net 67. Dick Ho was tied at 2nd with a net 73 and in "C" Flight, Bill Dang shot a net 69 and tied for 1st while Ed Matsuoka with a net 70 was 2nd and Naomitsu Tajima with a net 71 was 4th. Ray Fujikami apparently had a wee bit of trouble and shot an incredible gross 123 for a net 101. It must be added, that our traditional grand slam winner Bill Dang's net 69 for the day included 2 OB's and 1 water hazard. . . .

The nonhandicappers played the Calloway system with Tom Richert netting 81, Doug Bell grossing 92 and Jim Harrison grossing 86.

continued page 224

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Warnings: Safety of sulfonamides in pregnancy has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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Notes and News *continued from 220*

Life in These Parts

After a **Scott Halstead** lecture on the current status of rubella in Hawaii at a recent Children's Hospital noon conference, **Francis Nance** pleaded, "I would like to have you join my one man crusade to use the term *Morbilli* for *Rubeola* to eliminate the confusion between rubella and rubeola. . . ."

Yoshiki Ushiyama, who is primarily a fisherman and yachtsman, tried his hand at golf recently as a guest of **Ed Izawa**. He started with a dozen new balls a neighbor had given him and lost 15 balls playing the 18 holes at Mid Pac . . . averaging less than a ball per hole. . . . **Takakazu Fukumura** who has taken lessons previously and who was also in the foursome did somewhat better. . . . (The undaunted)

Conference Humor

A 47-year-old woman was admitted for bone pain. She had had both cervical and lumbar disc surgeries and 19 surgeries to her knee over the past 8 years. She had been even labeled a Chemical Poison Syndrome for lack of a better diagnosis and had been treated variously with Alkeran and P32. She had an equivocal electrophoretic pattern and only a 7% plasmacytosis which was not conclusive for multiple myeloma. Moderator **Noboru Oishi** was curious: "What is her racial extraction?" **Quint Uy**: "Multiple extraction. . . . She is Chinese-Hawaiian-Irish." Oncology nurse, **Miss Donley** defended the Irish for obvious reasons: "It can't be her Irish part." Quint pointed out, "She has outlived her doctor who did the surgeries." Noboru: "What are you going to tell her?" Quint suavely: "That she has an abnormality of her blood. . . ." Noboru had a brilliant afterthought: "How about doing acupuncture?"

Visiting Physicians

Low key speaker **Barth Hoogstraten** was visiting oncologist for May from the U. of Kansas. Barth, blondish, with high forehead and horn rimmed glasses spoke with a slight Dutch accent and was one of the most relaxed speakers to grace these shores. . . . We were impressed with his individualized, non-dogmatic humanized approach to cancer therapy. So low key was Barth that we were frankly unimpressed with the first lecture we attended and to our later chagrin, caught only his last lecture. . . . Herein are a few Hoogstratenisms:

"Chemotherapy in general is a fiddling around with drugs. . . . Psychologically, the surgeon is not a fiddler. . . . He cuts things out. . . . He itches for action. . . . The internist on the other hand says, 'Let's try it out' . . . Oncology is like that. . . . Formerly we would think in terms of weeks, but now we think in terms of months. . . . The internist is a man who takes his time. . . . (From his discussion: The Goal of the Internist in Oncology).

re, Ovarian Ca: "First, surgery to remove most of the cancerous tissue, then follow with radiotherapy. . . . Chemotherapy is a last resort. . . . Treatment of ovarian tumor should be a combined team approach. . . . The surgeon should discuss the case with the radiotherapist."

re, Chemotherapeutic drugs for ovarian Ca: "I would use Alkeran 8mg per day for 5 days, then 4 weeks later another course."

re, Cytosan: "I do not like this drug myself."

re, Breast Ca: "By all means have a scheme in your institution. . . . I don't care if you use my scheme or not . . . but have a definite scheme. . . ."

re, Random irradiation of ovaries in post op breast Ca: "There is a significant statistical difference in women over 60. (re, Nissen-Meyer's results). I don't know why this is so. . . ."

re, Hormone therapy for breast Ca: "Use the oral stuff. . . . I don't like injections. . . ."

continued page 226

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Notes and News continued from 224

re, Cooper's Regimen: "Cooper is not an oncologist much to the chagrin of the oncologists."

re, Treatment of odoriferous inflammatory breast Ca: "Apply Yogurt to remove the odor."

re, Adriamycin and Daunorubicin: "These are drugs I reserve for the patient who is practically dead. . . . They are so darn cardiotoxic. . . ."

Charley Judd was curious about the role of hypophysectomy: "Hypophysectomy does not play a role in my book. . . . There was this big conference in Washington with 30 experts, an international group. . . . The thing that flapped our ears was when the English got up. . . . They had decided that hypophysectomy was to play a role. . . . It wasn't until they had killed 10 to 12 patients that they decided to stop. . . . The surgeons were doing hypophysectomy without special training . . . not even cadaver surgery. . . ."

In summary, **Barth Hoogstraten** said: "I was supposed to talk about chemotherapy . . . but I have tried to emphasize the importance of cooperation of physicians of various disciplines. . . . The approach to cancer starts with the family practitioner. . . . He is the one who selects the surgeon—not his friend, but one most suited for a particular operation—and later selects the radiotherapist or chemotherapist. . . . Cancer is a disease of the whole medical community and we should take into account the technique of working together. . . ."

The visiting professor of surgery in April was **David Hume** from the Medical College of Virginia. David, bronze complected, clean cut, with barbered brown hair was simply brilliant and convincing and we enjoyed his crispness. . . . We caught his lecture on gastric ulcers and got the following message:

"All gastric ulcers should be operated on because of

the likelihood of recurrence and of cancer. . . . **Bilroth II** is the best operation for gastric ulcers because it prevents the jet through the pylorus. . . . Intestinalization of the gastric mucosa is caused by an incompetent pylorus and is secondary to the regurgitation jet of duodenal juice (bile and pancreatic juice). . . . Intestinalization increases the level of alkalization and the ulcer is always on the alkaline side of the stomach. . . . Perhaps the most unfortunate thing is the development of the fiberoptic scope which left the management in medical hands. . . . I agree with **Joseph Strode** that treatment of gastric ulcer is surgery and that vagotomy is useless. . . . The recurrence rate of gastric ulcers after medical treatment is about 70% . . . certainly at least 50%. . . ."

**Notes From the 116th
Annual HMA Meeting**

Our astute HMA prexy **Herb Chinn** opened the 116th HMA Meeting with three concise critical statements: "Any new business? Any old business?" He paused and noting only sleepy silence, finished with: "If not I'll turn over the meeting to Chairman **Varian Sloan**. . . ." **Varian** more verbose, announced, "I'd like to introduce the two who did all the work. . . . Commissioner of Internal Affairs, **Coolidge Wakai** and Program Chairman **Herbert Kitamura** (sic for **Uemura**). . . . He then introduced the first speaker, **Edward Gall**, pathologist-lecturer par excellence, from the U. of Cincinnati, and said tartly, "I hope you noticed that I didn't make any smart remarks about your name, sir."

Edward Gall, a genial, white haired intellectual giant with a most remarkable gift of gab and wit first told the story of the Indian chief who stood at the corner of Broadway and 42nd. Everytime a girl passed by, he would lift his hand solemnly and say "Chance!" A curious



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observer who had noticed this strange behavior was finally unable to contain himself, approached the chief and asked, "You a real Indian? Every Indian I know says, 'How!' not 'Chance!'" The Chief replied, "Me know how . . . I want chance!" Ed Gall's topic was "The Panorama of Hepatitis, Viral and Other" and with some modesty declared, "May I lead you down the primrose path. . . . Though I don't know where it will lead. . . ." And he did, starting with viral hepatitis and covering the hepatitides, chronic active to alcoholic. . . . "The liver, like all types of organs and cells, has more to it than meets the eye. It differs etiologically and prognostically." Who would have thought it possible for us to stay awake when tissue slides were being tossed on the screen in pitch darkness and so early in the morning at that? But we did, for Ed imbues the audience with his enthusiasm. We lost the moral of the following story, but we insert it for its poignancy in any situation: A woodpecker got fed up with the fog in Cincinnati and decided to fly south. So he flew and flew for days and nights till he encountered stormy weather over lower Alabama. He alighted on a bough of a tree and nestled close to the trunk for shelter. He saw a worm and being hungry, he pecked at the morsel. . . . Just then, a bolt of lightning struck the tree. . . . Stunned as he was, it still occurred to him, "My goodness, you never know what you can do until you get away from home. . . ."

We sauntered over to Session C to listen to **Harry Marsh III**, clinical pathologist from Union Memorial Hospital, Baltimore, speak on "Laboratory Service to the Patient on Admission." An excellent speaker with well prepared slides, Harry was first introduced by **Meryl Haber** who told the following clinical pathologist joke: A patient goes to a doctor's office and tells the nurse, "Miss, I have a pain in my arm which is killing me." The nurse with typical office nurse perfunctoriness: "No one sees the doctor without a urinalysis." There ensued

a heated discussion on the relative merits of a urinalysis for a painful arm . . . and while this was going on, the doctor left as it was closing time. The nurse finally handed the patient a urine bottle to take home. Angry at not being able to see the doctor, the patient had his dog, his wife and his daughter all urinate in his specimen bottle. Next day, he was ushered into the examining room and the doctor said solemnly, "Mr. Jones, you have a real problem." Jones: "How can you say that when you don't even know my problem?" Doctor: "I can tell from the urinalysis that your dog has rabies, your wife has gonorrhea, your daughter is pregnant, and you are masturbating too much."

Harry Marsh had some interesting and practical suggestions for hospital laboratory servicing which can cut down the cost and length of hospitalization. His survey showed that the laboratory is poorly utilized for the first 24 hours of hospitalization because peak admission is between 3 to 6 p.m. and that the laboratory is staffed oppositely, ie, everyone in the lab goes home just as the patients come in. At Wesley Medical Center, the lab staff in the 2nd and 3rd shifts were beefed up, a cross over responsibility of shifts instituted, viz with a half hour overlap of staff. The Center also set up a "bleeding room" in the admissions area so that lab personnel need not chase all over the hospital and a nurse admission program started wherein the doctor can be called to start his lab tests immediately upon admission of his patient. Harry states, "Complaints are rife about the cost of medical care while modern scientific medicine demands expensive instruments. So the only obvious way would be to take care of people 'on the hoof' so to speak and thereby shorten their stay." The keys to his program are: an admitting nurse program; physician willingness; bypass of housestaff education; one point bleeding; a well trained flexible night crew; a clinical pathologist on call until 6-7 p.m. with frequent call backs till midnite. Harry

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feels that "our habit patterns have to change if we are to reduce hospital costs and improve medical care."

The Wednesday morning session was "Tumors of the Head and Neck" by William Russell, head of the Department of Pathology at the U. of Texas. Before launching into his well prepared talk on the tumors of the head and neck, Bill first gave a pat on the back to our local tumor registry: "I would like to recognize the Hawaii Registry as the best in the nation. You have a rare opportunity here to study the various racial characteristics of tumors." Then, he lost us. . . .

We again picked Session C where Willard Miyahira presided in Harry Marsh's talk on Emergency Room Toxicology." After Harry had described a patient who survived an alcohol level of 500mg%. Mike Okihira inquired, "Your alcohol levels seem very high." Harry explained, "100mg% is the legal limit, but it can reach 180mg% simply after cocktails and 280mg% or higher with 15 to 18% carboxyhemoglobin in some one chain-smoking and drinking beer. I have seen a patient with 400mg% still walk."

When Doris Jasinski asked, "What is the least dangerous sleeping compound?" Harry reflected, "Certainly, not Doriden for 500mg% will be a 'beddy by' dose. . . . Placidyl is dangerous, but not as dangerous as Doriden. . . . I really don't know. . . . Some people drink and that's safe. . . . Most toxicologists drink, but do not take drugs" He went on, "In Kansas, we drink methanol, alcohol, isopropyl, street drugs and horse tranquilizers. . . . In the Pacific Northwest, Ritalin seems to be a problem. . . . In Kansas, Dilantin is also a street drug," and concluded with the familiar ad slogan, "Better living through Chemistry."

What sounded like a staid talk on the value of autopsies, Ed Gall's "The Contributions of Necropsy to Medical Progress," turned out to be an epic well worth reproducing in full if we had the space. The following was extracted: "Bread is for eating, wine for drinking—the autopsy has been and continues to be food and drink to medical practice. . . . It suffers the disparagement of

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the ignorant and the patronizing smiles of the sophisticated, but the necropsy still moves along at its time-honored, steady pace, maintaining standards, contributing to knowledge and even, on occasion, stimulating the slug-gard. . . . The path to knowledge follows the course of observation, dissection and analysis, whether these be carried out on bodies or on ideas. . . . The necropsy has long been both a checkrein and a goad—a signal to halt and a beckoning hand. . . . In essence it is a means of instruction—it is a mechanism for correction—it is a pathway to discovery—it is a provocation to and a source for investigation—it is a storehouse of useful supplies and an avenue for technical opportunity. . . . It is also, I needn't remind you, an essential handmaiden of the law. . . . None can know disease unless he first sees it not as a battery of chemical values or as an oscillating wave on a polygraph, but as it is within the human body. . . . Only a short time ago, a visiting clinician from one of our more enlightened universities appeared as a dis-cussant at our bi-weekly clinicopathological conference and remarked that this type of session was in disrepute at his institution, since it has lost its appeal and its use-fulness. This he said to a standing room only audience of well over 200 students and physicians. . . . 'None so blind as those who can see.'

Is it true that the well is dry and there is little save rank muddy water left to sip? . . . They say that the whole story is told and that the necropsy is obsolete. . . . I am sure you will all agree that the best subject for the investigation of man's ills is man himself and that, in-valuable as are the rat, the hamster, and the aardvark, and also their genes and enzymes, their reactions to in-jury, psychic or otherwise have little parallel to those in man. . . . All clinical phenomena in the last analysis stem from disorders of the cell, and the final proof of the existence of disease awaits its elucidation by the pathologist. . . .

The autopsy room is obviously not a house of the dead, devoid of useful purpose, lacking in intellectual activity, or aimless in its contributions. . . . To con-

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template shutting it off or restricting its activity in order that busy clinicians may find titillation at the bedside or so that pathologists may be occupied more usefully in the construction of quality-control charts or the priming of multichannel autoanalyzers, reflects a curious intellectual myopia. . . . Each age has had its great men who have decreed pontifically that one or another discipline has reached its maximum and had nothing left to excite the mind or elevate the soul. . . . With all the diseases that remain to be discovered, with all the old ones that require reevaluation, with all the new techniques as yet unused, with all the therapeutic regimens yet to be introduced, and with complex computers waiting, expectantly whirring fodder in the form of data, it would seem that the autopsy still had a small way to go. . . . Medicine had reached remarkable levels of excellence, and its minions are more highly dedicated than ever before, but there is no endeavor of man, however exalted, which can prevail without objective evaluation. . . . In respect to the practice of medicine, what substitute is there for autopsy?"

We had heard about John Rebeck's "skin window" technique wherein the forearm skin is slightly scarified, an antigen added and slide placed directly on the site and changed every 3 hours to see what type of cells are present. His lecture had the awesome title, "New and Old Diseases of Basophils and Mast Cells, Ulcerative Colitis, Hunner's ulcer, Penicillin Sensitivity and the Mucopolysaccharidoses," but we felt "nothing ventured, nothing gained" and ventured. . . . Without the background of his first lecture, we found it difficult to follow his rambling nevertheless enthusiastic lecture. . . . The Rebeck thesis apparently is that basophilic granulocytes from the blood and hyperplastic mast cells in connective tissue both secrete heparin, histamine and chymase and that this is the mechanism behind such diseases as ulcerative colitis, interstitial cystitis, etc. The skin window technique which can demonstrate increased numbers of basophilic granulocytes can therefore be diagnostic for

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these diseases, and also for staph sensitivity, transplant incompatibility, cold urticaria, Hurler's disease, etc.

We also managed to take in **Harry McFadden, Jr.**'s lecture, "Current Status of Antimicrobial Susceptibility Tests and Their Utilization in Medical Practice." Drake Will described Harry as "one of those rarities—a microbiologist as well as a pathologist." We found Harry McFadden, tall, well groomed, youngish, calm voiced chairman of the U. of Nebraska Med School's Microbiology Dept. to be invaluable to the clinician because of his concise, logical presentation of an otherwise difficult subject. We learned that:

In vitro determination measures the potency of antibiotic agents in solution, the concentration of the drug in blood, body fluids or tissue and the susceptibility of a given microorganism to known concentrations of an antibiotic.

Antibiotic susceptibility tests are of two types, the dilution tests (including broth and agar techniques) and the diffusion tests (disc and cup plate assay techniques). The dilution tests are critical when accuracy is paramount.

Antibiotic susceptibility tests should not be used when the causative agent has a predictable course and when normal flora or isolates of doubtful pathogenicity are found.

Most hospitals use the disc diffusion method which measures the bacteriostatic levels for most pathogens. But there should be access to a dilution technique esp the broth method for measuring bacteriocidal levels esp with SBE, and severe septicemias and bacteremias. Large laboratories (eg, the Mayo Clinic) can adopt the agar technique. The cup plate technique for blood levels assays the patient's serum against the patient's organism.

On Thursday evening, we caught HMA prexy Herb Chinn's eloquent presidential address which gives clear direction to the medical society and which we found to be profound, prophetic and sound. You can find the complete text in this issue.

AMA prexy **Wesley Whitfield Hall** acknowledged a lengthy introduction by **Herb Uemura** with: "After that introduction, written by my wife, there is little left for me to say." (We later learned that his entire speech was from memory for he had forgotten the text of his speech in his hotelroom). Here are a few exemplary quotes which we feel are good for our sorely beset souls:

"Let's talk about the greatest *cause* of all, which to me, is the healing arts."

"The progress of medicine has been fantastic over a relatively few short years."

"The American medical profession and medical professions all over the world working in harmony will conquer disease."

"There are more of God's noblemen in the medical profession than any other profession, including the clergy."

"When you hear criticism, find the source,' my father used to say. . . ."

"Why are you a doctor—why do you work so hard? You are dedicated. . . . You are a doctor at heart."

"He who profits most who serves best."

"We have a magnificent obsession."

Sportsmen's Nite

The Sportsmen's Nite, is without any doubt, the most important event of the annual HMA convention. It is a time to let our hair down, do a postmortem on the various sporting events and above all, renew our friendships over drink and food. . . . It is well attended by participants and non-participants as well, and judging from the number attending it doesn't seem to matter one iota whether it falls on the traditional golf tournament day or not. This year's event was not only a sportsman's delight but a gourmet's delight as well for Cool Wakai had arranged with **Tom Fujiwara's** brother who owns Natsunoya Tea House for a real palatable treat of lobster, crab, shrimp, duck, sashimi, skewered pork, sushi etc. all exquisitely prepared and all the liquor one can hold. . . . The 100 plus who attended the stag affair were

described by our master MC of wit and humor, **Paul Tamura**, as "the most important group in the medical society. . . . These are the athletic supporters. . . . Every segment of society needs something to hold it up. . . ." AMA prexy Wesley Hall was at his extemporaneous best with another morale boosting talk: "This, I can assure you. . . . You belong to the greatest profession. . . . Medicine is the greatest avocation of all. . . . We in America have a monopoly on science. . . . Ours is a common brotherhood. . . . The advancement in medicine is because of men like you. . . ." It sounded suspiciously like a coach's halftime locker room booster talk, but it was good medicine for our oft shattered egos. . . . Wesley then told the following story: A psychiatrist asked his patient, "Did you have relations with the wife before you got married?" Came the forthright answer, "I don't really know. . . . What was your wife's maiden name?"

We could overhear the dialogue between last year's HMA golf tournament winner **Al Ito** and **Nobu Nakasone**. When Al, a 10 handicapper learned that Nobu, who was in his foursome, was a 8 handicapper, he asked, "How come you said we were playing even?" Nobu masterfully squelched an otherwise explosive situation with: "Well you know you should really be an eight too."

Bill Davis, our enthusiastic Bow & Arrow Tournament chairman reported catching 38 mumpachi, 2 uku's and some other big fish, but no sheep or boar. With Bill went half mountain goat **Roger Ogata** and **Jim Cherry's** son and they stalked the sheep in the hinterlands of Kamuela. Bill promised to give bow and arrow lessons before the next tournament, but when we learned how exhausting the trek up and down was, we felt rather disinclined. . . .

H. Yokoyama, the chairman of the first annual HMA skin diving tournament reported how eight skin divers flew into Kalaupapa, thanks to permission from **Ira Hirshy**, and how they exhausted their \$40.00 entry fee on the plane fare and the steaks and beer, and were left without funds for prizes. Fortunately, **Paul Tamura's** Path Lab came to the rescue with an unsolicited donation. First prize went to **Ted Tseu** for "The Biggest Fish Speared" (and for arranging the reception by the **Ogawa's** of Kalaupapa). When **Buster Richardson** wanted to know how big were the fish, Ted admitted spearing two four pound size uhu. The 2nd prize for "The Most Fish Speared" went to **Roger Ogata** and 3rd prize went to **Tom Riebert** who went over to collect shells and ended up catching the most lobsters (7 spiny creatures ranging from 3 pounds to 1 pound sizes in a single afternoon). If more prizes had been available, **Herb Uemura** would have been awarded for "The Biggest Fish Hooked" (a 4 lb. papio caught trolling), **Bill Davis** would have been awarded "The Best Hiker and Kahuna" trophy (Bill insisted we piss on our Wana pokes to reduce the pain and swelling. . . . Fortunately Roger Ogata with his first aid kit ministered to our injuries with steroid cream, antihistamine tab and ace bandage), **Mark Schlaeter** of Kahului would have been awarded "The Most Enthusiastic Diver" award and **Jim Ball** "The Best Underwater Photographer" award.

Fishing Tournament chairman **Andy Morgan** gave a hilarious account of how three boats with 14 fishermen fared better this year. . . . As you recall, last year's tournament was a white wash with nary a fish caught and Andy's boat developed gear trouble and could only reverse. . . . He had to reverse all the way back from off Koko Head to Kewalo Basin. . . . "We didn't chum over the side, but some simply chummed into the cabins." **Ralph Hale** won the First Prize Mahi Mahi with a 40 pounder while **Ted Tseu** took 2nd Prize with a 32 pounder. **Jack Scaff** took 3rd Prize with a mere six pounder. Tied for First Place Aku Division were **Herb Uemura** and **Paul Tamura** (his first venture), each with six pounders. **Mike Hase's** 5½ pound Kawakawa took First Prize in that division while **Roy Kaye's** 5 pounder took 2nd. The "Most Fish" award was won again by **Harold Sexton** on the *Alo Kai* with 11 fish caught. The traditional Hard Luck Trophy was won by **Phil Jones** "who vomits each year and catches fish, but who this year vomited and failed to catch anything." **Ralph Hale**

continued page 235

Maui

The meeting of the Maui County Medical Society held at the Club 19 on March 21, 1972 was a memorable and stimulating one, made so by the presence of the Medical Auxiliary and visiting dignitaries from Honolulu.

The Society was delighted to have for dinner the following Auxiliary members: Gwen Fu, Betty Rossberg, Ginny Moran, Florence Achong, Mary Jo Dietrich, Ilona Briley, Marcy McDonald, Edith Izumi, Fumie Uehara, Helen Burden, Betty Fleming and Lorraine Iaconetti.

The VIP's visiting from our statewide association were HMA President, Herbert Chinn, Elizabeth Anderson, M.D., Assistant to the President (a charming female Psychiatrist from Bluegrass County) and Mr. H. Tom Thorson, the inimitable HMA Executive Director.

Our youthful County Society president, Denis Fu, started the meeting on time as usual and during his introduction of our HMA president, he mentioned the U.S. President's visit to China and gave the impression that this is a Chinese year, the HMA president and our County Society president being Celestials themselves.

HMA President Chinn mentioned EMCRO (Experimental Medical Care Review Organization) and Dr. Payne's study in medical care review of ambulatory and hospital patients.

A Blue Ribbon Committee composed of the last six past presidents are now working on the internal organization of HMA.

Another project of the HMA is the integration of hospitals as a step towards a 4-year medical school.

Last January 1971 the Cancer Act was passed by Congress organizing 15 Research Centers. The University of Hawaii was chosen as a cancer center and has embarked on a Demographic Study, ie, diseases of cancer in relation to population. The U of H is now applying for funding of this project which the HMA president feels should be a community project.

The latest venture of HMA in collaboration with CHP (Comprehensive Health Planning) and RMP (Regional Medical Program) is Emergency Medical Care for which \$8 million is available during a 3-year period. The first phase is equipment and communication, second phase is training of medical technicians and the third phase is implementation of the project under L. Wong.

T. Chang of Honolulu is now looking for instructors in Emergency Care to be paid \$35.00 per hour.

The CPR program could help immensely in the training of technicians and in the implementation of the project.

A bill is presently in the legislature regarding the certification of Emergency Medical Technicians to be a function of the Board of Medical Examiners.

Manpower needs are being met by the training of Physicians Assistants and Medics, Registered Nurses are being considered probable Physician Assistants.

In reply to a query by Mark Sowers, President Chinn remarked that it is still hazy what is to be done with Peer Review and this problem will rest on the action of the House of Delegates under W. Lee.

Tom Thorson enumerated the legislative program HMA is now engaged in:

Bill 1950 Workmen's Compensation Act (HMA has a suit pending against Hasegawa of the Department of Labor regarding fees; appeals board to act on it). A mechanism to determine fee schedules such as joining RSV to the Consumer Price Index is under consideration. Tom recommends writing our legislators to support Bill 1950.

Malpractice legislation. Exemption of the Records of Review Committees from subpoena, passed in the last session.

A bill to eliminate contingency fees for attorneys; re-definition of statutes of limitation to 1 year after discovery

and 4 years after alleged neglect was made as maximum period for claims. HMA working smoothly with Argonaut on malpractice insurance.

Med school legislation being supported by HMA.

No stand has been made by HMA regarding *no-fault car insurance*.

National Health Insurance for 1972 is remote but for 1973 is probable and may include medicredit features. Possible coalition of Wilbur Mills with Kennedy may threaten AMA stand.

The Bennet PSRO has a good chance to pass in 1973.

HMO's must not be imposed.

The Honolulu County Medical Society (HCMS)-HMA share in expense is now 30-70 and should be 50-50.

The amalgamation of MCMS of 49 members and HCMS of 700+ members is still under consideration.

During the debate on the selection of council members featuring Drs. Uehara and Moran, President Chinn suggested that the County President could be the alternate for the Council.

Debate on the criteria for membership in the HMA for Osteopaths was actively participated in by Drs. Sowers, Iaconetti, Fu, Moser, Chinn and Allred.

Incoming HMA President Iaconetti opined that the Maui County Medical Society is most qualified to, and should do the study regarding criteria for Osteopaths' membership in HMA. President Chinn and Dr. Anderson both agreed.

An unidentified member remarked that HMA committees will have to switch from chow-mein menus to spaghetti when Iaconetti takes over the State-wide medical society next May.

Everybody including the reticent majority had a bellyful of information and amusement. Discussions galore would have flourished but our conscientious county president, ever mindful of our guests and members' welfare, adjourned the meeting at 9:30 P.M.

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with his largest fish garnered the Perpetual Trophy while **Phil McNamee**, **Francis Au**, **Bob Peyton** and **Murray Berger** all won consolation prizes. Andy was solicitous, "We urge you to sign up. . . . We drink a lot of beer and the water is not always rough. . . ."

Through the efforts of hardworking chairman **Don Maruyama**, the Golf Tournament went off beautifully at the Francis Brown CC, but we would still have preferred the traditional courses, Waialae, Mid Pac or Oahu Country Club. The net scores were all surprisingly low in spite of the wind. Buster Richardson who learned his golf caddying at the Old Palolo Golf Course copped Low Gross honors with a 77 and won the TV set donated by Path Lab. When Wesley Hall joked that a doctor's game improves when he neglects his practice, Buster admitted, "I'm getting to the point where I don't let my practice interfere with my golf." **Joe Nishimoto** and **Manuel Abundo** both shot net 65's to tie for the Robert Miyamoto Low Net Trophy which Joe won with a toss. Manuel got the TV set and Joe settled for Herb Chinn's presidential trophy (an exquisite Kutani plate) and a digital clock radio. Clustered at net 66 were **Glen Kokame**, **Ed Izawa** and **Don Maruyama**. At net 67 were **Tom Kobara**, **M. Nicholson** and at 68 were "Honest" **Ed Emura** (who corrected a posted 67), **Jim Cherry**, **Harold Johnson** and **Wini Lee**. Clustered at 69 were the following: **Bill Dang**, **Frank Fukunaga**, **Ed Kagihara**, **Masaru Koike**, **Ed Matsuoka**, **Dick Omura**, **Herb Takaki**, **Quint Uy**, **Robert Wong** and **Sam Yee**. At net 70, where the prizes ran out, were **Allan Young**, **Hideo Oshiro**, **Richard Ho**, **Nobu Nakasone**, and **Clarence Sakai**.

For the nonhandicappers playing under the Peori system, **Phil McNamee** won with a unbelievable net 46 and **Henry Fong** was second with a net 64. **Jim Harrison** with a gross 81 ended with a miserable net 81.

The tennis tournament chaired by **Yutaka Yoshida** was held over 3 weekends with participants playing regular sets. The traditional winners **Leabert Fernandez** and **Yutaka Yoshida** (whose combined ages is 120) again won the Perpetual Trophy for the fifth successive year. The Consolation Flight was won by **George Suzuki** and his druggist partner, **Tommy Kang**. The results of the tournament were as follows:

- First Round:
Mehta-Roth defeated Allin-Lu 6-2, 6-1
Shimonishi-Arakaki defeated Bennett-Dizon 6-0, 6-2
Tottori-Sia defeated Suzuki-Kang 6-2, 2-6, 6-4
Scully-Job defeated Balfour-McNamee 7-6, 6-4
Tom-Ching defeated Penoff-Ho 6-0, 6-1
Second Round:
Doo-Joseph defeated Mehta-Roth 2-6, 6-2, 6-4
Scully-Job defeated Tottori-Sia 6-4, 4-6, 7-5
Fernandez-Yoshida defeated Tom-Ching 6-0, 7-6
Semi Rounds:
Shimonishi-Arakaki defeated Doo-Joseph 6-4, 7-6, 7-6
Fernandez-Yoshida defeated Scully-Job 6-4, 4-6, 6-3
Finals:
Fernandez-Yoshida defeated Shimonishi-Arakaki 7-6, 6-4
Consolation Bracket:
First Round: Balfour-McNamee defeated Penoff-Ho 6-1, 6-2
Second Round: Balfour-McNamee defeated Allin-Lu 6-2, 6-3
Suzuki-Kang defeated Dizon-Bennett 6-2, 6-3
Finals: Suzuki-Kang defeated Balfour-McNamee 6-4, 6-3

Our "Angels"

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6. The pharmacist shall maintain a patient medication record system.

Pharmacists must maintain professional responsibility for drug supply and drug use control for the benefit and protection of the patient and the profession. The NPIC includes a model operational review system for the accomplishment of peer review and continuing educational exposure for the pharmacist.

It is recommended that peer review be a function of the Pharmacy Service Evaluation Committee (PSEC). The committee to be composed not only of a selected group of local practicing pharmacists, but that the physician or prescriber, consumer patient, and insurance administrators be represented. The consumer-patient role in the PSEC is to bear witness that the profession is policing itself with the purpose of providing the public with quality pharmaceutical service efficiently and will act as the educating arm of the consumer to the program.

The purpose of PSEC shall be to review all instances which deviate from the parameters as established under utilization review procedures, brought before it by insurance carriers, government agencies, physicians or patients. The committee should be concerned with the quality of pharmaceutical services provided taking into consideration cost. The committee in setting parameters should act to keep utilization of pharmaceutical services consistent with accepted standards of practice for the geographic area it serves.

The scope of the peer review committee shall be to:

- a. protect the patient from any pharmacy that may not provide those pharmaceutical service benefits established by the foundation.
- b. protect the pharmacy from arbitrary accusations and unreasonable conditions of participation.
- c. accept documented complaints from all responsible sources involved in the program.
- d. review such documented complaints, records and other pertinent information which may be presented to it for the purpose of recommending appropriate action.

The PSEC is obligated to report its findings and make recommendations to the foundation. Should an individual participating member disagree with the findings of the committee, an appeal mechanism is provided.

The responsibilities of the PSEC are sixfold:

1. PSEC should act as a clearing house for the foundation.
2. PSEC should develop standards of pharmaceutical practice for the area.
3. PSEC should monitor these standards.
4. PSEC should educate pharmacists to its concept and activities.
5. PSEC should educate other providers of health care as well as insurers, fiscal intermediaries, administrators and consumers to its concept and activities.
6. PSEC should develop a liaison with local medical foundations.

Equivalent importance is given to drug utilization review an important fiscal control involving co-payment charges, co-insurance and limitation in maximum quantity of drug supplied.

With regard to immunity from liability for members serving on these review committees, the State of Hawaii has a statute protecting those so serving on committees to improve the quality of care and service.

The real issue before pharmacy as we move into new health care delivery systems as described above is the need to establish standards for quality pharmaceutical services that insure that *all* pharmacies are providing the necessary level of pharmaceutical services without charging for factors which increase the cost of pharmaceutical services but do not contribute to the quality of such service. The age old price controversy is a symptom of

a deeper problem in pharmacy, rather than being the problem itself.

I challenge the Hawaii Pharmaceutical Association and the Hawaii Board of Pharmacy to develop and implement minimal meaningful essentials of pharmaceutical practice in Hawaii. I charge each pharmacist to live up to the APHA Code of Ethics, "A pharmacist should render to each patient the full measure of his ability as an essential health practitioner."

Lord Byron says: "But words are things and a small drop of ink falling like dew upon a thought produces that which makes thousands, perhaps millions think."

Reference: *Guidelines for the formation of A Prototype Pharmacy Group Practice* including Model Operational Review System . . . NPIC.

Slants and Angles continued from 203

"More recently it has become rather general knowledge that a 'good trip' can be had if one ingests three to five grams of isoniazid. There has been some speculation about the pharmacological relationship between isoniazid and its early cogeners and LSD. At any rate, these communities where large amounts of isoniazid can be found may expect to see more young people who overdose in an attempt to simulate an LSD trip."

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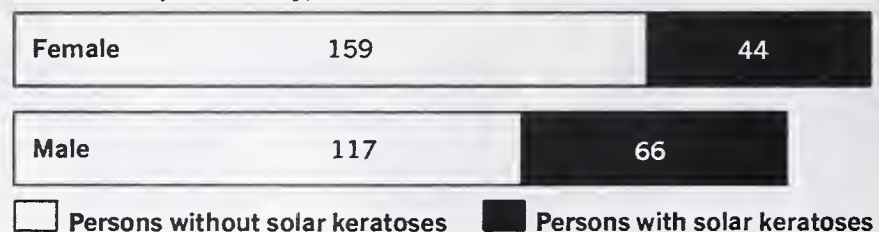
What it means to live and work in Tipton County, Tennessee

**Persons who are white and
over 40 have one chance in four
of having solar keratoses...
which may be premalignant**

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons
over 40 in Tipton County, Tennessee**



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



JULY / AUGUST 1972

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rheumatoid arthritic blowup... **Tandearil**[®] Geigy oxyphenbutazone NF

tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. **Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B) 98-146-800-E

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Will his return to work mean the return of undue psychic tension?



When it's mandatory to keep the post-coronary patient calm, consider Valium (diazepam).

Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. If he experiences excessive anxiety and tension because of overreaction to stress, your prescription for Valium can bring relief. During the period of readjustment Valium can quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

Valium® (diazepam)

For the tense cardiac patient who must be kept calm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg *b.i.d.* to *q.i.d.*; alcoholism, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d.* *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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THE GOOD THINGS
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A living trust. It has many benefits for
you right now. Like providing
experienced, day-to-day management of
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responsibility. We become
your investment advisor, tax expert,
bookkeeper and property manager.
We do it all.
Which leaves you free to enjoy the good
things about today. . . and still provide for
your family's tomorrows.*



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CC: Pain on Rt. side of face
Dx: Acute purulent bacterial Max. Sinusitis
X-Ray Interp: Waters - Clouding of Rt. Max. Sinus



There are many frustrations in treating acute sinusitis.

Cleocin manages most of the bacterial ones.

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It's helpful to have an antibiotic like Cleocin HCl (clindamycin HCl hydrate, Upjohn) that can take care of most of the gram-positive bacterial problems related to the disease.

As one study* of 52 outpatients showed, acute maxillary sinusitis was associated with staphylococci in 50% of the group, with pneumococci in 25%, and with streptococci and various other organisms (chiefly gram-negative) in the remainder. Significantly, one-half of these staphylococcal infections were resistant to both penicillin and tetracycline (all were sensitive to erythromycin and chloramphenicol). Although not a part of this study, many other clinical and bacteriologic reports¹ have shown that such gram-positive bacteria, which most often are associated with acute sinusitis, are usually susceptible to Cleocin.

Can be taken before, with, or after meals

The total absorption of Cleocin is virtually unaffected by the presence of food in the GI tract.¹ Cleocin thus can be administered as prescribed without interfering with the patient's mealtimes.

Useful in patients hypersensitive to penicillin

Cleocin's chemical structure bears no relationship to penicillin or the cephalosporins. Cleocin therefore may be especially useful in patients with acute sinusitis who report a history of hypersensitivity to these antibiotics. Although hypersensitivity reactions have been uncommon with Cleocin, it should be used cautiously in atopic individuals. Cleocin is not recommended in the lincomycin-sensitive patient.

Please see following page for further prescribing information.



® 150 mg capsules

Cleocin HCl

clindamycin HCl hydrate, Upjohn

Side effects: In studies of 1,416 patients involving 92 clinical investigators, side effects were reported in 8.2%.¹ Diarrhea or loose stools were noted in 3% of these cases (one patient with bloody stools). In a few instances, diarrhea lasted several days. A slightly higher incidence of diarrhea or loose stools has been reported by some investigators in subsequent studies.



Toxicity: No irreversible hematologic, renal, dermatologic, or neurologic abnormalities have been reported.¹ Transient leukopenia and eosinophilia have been observed. Elevations of alkaline phosphatase and serum transaminases were observed in a few instances. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

In acute sinusitis and other upper respiratory infections due to susceptible staphylococci, streptococci, and pneumococci

Cleocin[®] HCl

clindamycin HCl hydrate, Upjohn

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin, Upjohn) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Cleocin HCl (clindamycin HCl hydrate) is indicated in infections of the upper and lower respiratory tract, skin and soft tissue, and, adjunctively, dental infections caused by gram-positive organisms which are susceptible to its action, particularly streptococci, pneumococci and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: Patients previously found to be hypersensitive to this compound or to lincomycin.

WARNINGS: Safety for use in pregnancy not established. Not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. Perform periodic liver function tests and blood counts during prolonged therapy. The serum half-life in patients with markedly reduced renal function is approximately twice that in normal patients; hemodialysis and peritoneal dialysis do not effectively remove Cleocin from the blood. Therefore, with severe renal insufficiency, determine serum levels of clindamycin periodically and decrease the dose appropriately. Should overgrowth of nonsusceptible organisms—particularly yeasts—occur, take appropriate clinically indicated measures.

ADVERSE REACTIONS: Generally well tolerated in clinical efficacy studies. Side effects reported in 8.2% of 1,416 patients. Of the total, 6.9% reported gastrointestinal side effects and 1.3% reported other side effects. Diarrhea or loose stools were reported in 3%. **Gastrointestinal:** Symptoms

included abdominal pain, nausea, vomiting and diarrhea or loose stools. In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. **Hematopoietic:** Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. **Skin and Mucous Membranes:** Skin rash and urticaria have been reported infrequently. **Hypersensitivity Reactions:** A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. **Liver:** Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

DOSAGE AND ADMINISTRATION: **Adults:** Mild to moderately severe infections—150 to 300 mg every 6 hours. Severe infections—300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections—8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections—16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β -hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

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CAN STOP POTASSIUM DEPLETION BEFORE IT STARTS WITH NO SACRIFICE OF THIAZIDE EFFECTIVENESS

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Insights into the ulcer-prone

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*Palmer, E. D.: *Clinical Gastroenterology*, ed. 2, New York, Hoeber Medical Division, Harper & Row, 1963, p. 206.

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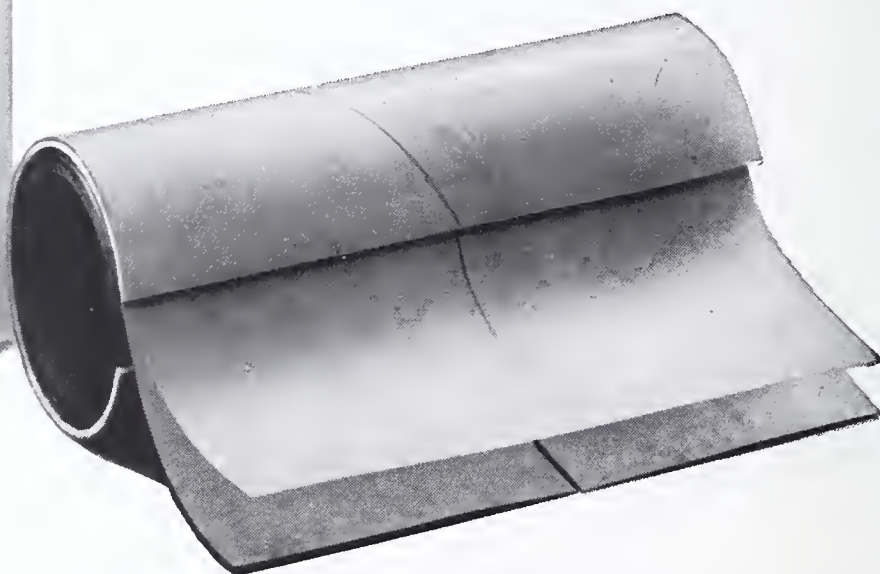
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Myocardial deaths were fewer than in other series, even before C.C.U.

Myocardial Infarction in Kaiser Hospital, Honolulu (1959-1967) – A Long Term Analysis

T. K. LIN, M.D., J. H. C. KIM, M.D., W. M. H. DUNG, M.D.,
E. H. MIYAWAKI, Ph.D., and J. G. BENNETT, M.D., *Honolulu*

Follow-up over eight years on 254 patients with acute myocardial infarction revealed several points of interest. Among them were the relationship of angina to progression of disease, over representation of Caucasians, under representation of Japanese ancestry, relationship between the location of infarct and mortality. Pump failure accounted for 15.2%, electrical failure accounted for 84.8% on long term mortality.

MORE THAN fifty years have elapsed since myocardial infarction attained widespread clinical recognition. During this time, many reports of large groups of patients with this disease have appeared in the literature.¹ The majority of the reports describe follow-up periods ranging from two to six years.

There are no reports in the literature of large series of cases on long term follow-up studies of myocardial infarction from a cosmopolitan community.²⁻¹² Bassett *et al*^{13,14} reported on factors for coronary heart disease in Hawaiian and Japanese men in Hawaii; however, they were unable to assess the long term follow-up and diagnostic validity in their material.

CLINICAL RESULTS

This communication concerns 317 patients with proven acute myocardial infarction admitted to Kaiser Foundation Hospital in Honolulu prior to the establishment of a coronary care unit (CCU). Two hundred fifty-four patients were followed

from 1959 to 1967. Sixty-three were lost to follow-up. A detailed questionnaire was used in following these patients.

The criteria for acute myocardial infarction were based on admission history of chest pain or distress, characteristic changes in electrocardiograms, and enzyme abnormalities, including determinations of serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT) and lactic dehydrogenase (LDH) and occasionally creatinine phosphokinase (CPK).

Aside from classic changes in serum enzymes, transmural myocardial infarction was defined as the presence of a pathological Q wave, in association with the usual ST segment and T wave changes. Non-transmural myocardial infarction was made with alteration of ST segments and inversion of T waves, with absence of the pathological Q wave.

In our studies we have defined extensive myocardial infarction as having a peak SGOT greater than 300 units, with exclusion of hepatic disease, or pathological electrocardiographic changes involving five leads (three limb leads plus two V leads).

The ages ranged from 34 to 86 years, with an average of 55.4 years. Nearly 70% of patients who suffered from myocardial infarction were below 60; 33% were 51 to 60 years old (Table 1). The over-

TABLE 1.—Age distribution of patients with acute myocardial infarction.

AGE	NO. OF PATIENTS	PERCENT
31-40	18	5.7
41-50	98	30.9
51-60	105	33.1
61-70	63	19.9
71-80	26	8.2
81-90	7	2.2

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all man to women ratio in 317 cases was 4.3:1. After the exclusion of the 32 tourists, the man to women ratio was 4.5:1.

In our series of myocardial infarctions, Caucasians accounted for 63.7%, part Hawaiian 13.6%, Japanese 9.5% and Chinese 4.1% (Table 2). The

Further, patients with transmural infarction have a higher percentage with previous history of angina among non-survivors than among the survivors. Survivors have a much higher percentage of angina pectoris following acute myocardial infarction than prior to the initial acute episode. Percentage

TABLE 2.—Ethnic distribution.

ETHNIC EXTRACTION	ETHNIC DISTRIBU- TION IN OAHU, %	5 YR. ETHNIC DIST. ADMIT KAISER FOUNDATION HOSPITALS, %	PATIENTS		FATAL		OTHER CAUSES	NON-FATAL	
			NO.	%	NO.	%		NO.	%
Caucasian	30.5	44.2	202	63.7	59	62.4	12	72	55.3
Part Hawaiian	18	16.4	43	13.6	20	21.5	4	13	10
Japanese	28.8	12	30	9.5	9	9.7	0	17	13.1
Chinese	6.3	6.2	13	4.1	3	3.2	1	9	6.9
Filipino	6.7	7.5	13	4.1	1	1.1	0	8	6.2
Puerto Rican	.6	1.3	6	1.9	0	0	0	3	2.3
Cosmopolitan	1.6	11	6	1.9	1	1.1	0	5	3.8
Korean			3	0.9	0	0	1	2	1.5
Part Negro			1	0.3	0	0	0	1	.8
TOTAL			317	100.0	93	100.0	18	130	100.0

expected ethnic distribution for our study was obtained from all our hospital admissions over a five-year period.

The underlying causes of variations in the incidence of myocardial infarction among the different ethnic groups are outside the scope of this study. We hope to be able to analyze these in a subsequent study.

Table 3 suggests that patients with transmural myocardial infarction have a significantly higher percentage of previous history of angina than patients with non-transmural myocardial infarction.

TABLE 3.—History of angina before acute myocardial infarction.

NATURE OF MYOCARDIAL INFARCTION	SURVIVORS		NON-SURVIVORS	
	No. pts.	%	No. pts.	%
TRANSMURAL				
With Angina	46	22.3	50	45.0
Without Angina	110	53.4	42	37.8
Questionable	6	2.9	5	4.5
NON-TRANSMURAL				
With Angina	18	8.7	5	4.5
Without Angina	14	6.8	6	5.4
Questionable	1	0.5	0	
COMBINED				
With Angina	4	1.9	1	0.9
Without Angina	7	3.4	2	1.8
Questionable	0		0	
GRAND TOTAL	206	100.0	111	100.0

increase from 33% before the initial acute myocardial infarction to 66.5% (Table 4) after myocardial infarction probably represents progression of disease.

TABLE 4.—Percent of angina before and after myocardial infarction.

ANGINAL SYMPTOMS	BEFORE M.I.		AFTER M.I.	
	No. pts.	%	No. pts.	%
With Angina	68	33.0	137	66.5
Without Angina	131	63.6	61	29.6
Questionable	7	3.4	8	3.9
TOTAL	206	100.0	206	100.0

The immediate mortality among patients with first myocardial infarction is 12.3% and for repeaters is 22.0%. The average mortality among both first infarct patients and repeaters, is 14.8% (Table 5). We consider that the total mortality (prior to CCU care) in our series is significantly lower than the national average.

Among hospital deaths, 48.9% were due to pump failure (heart failure, cardiogenic shock), 29.8% were due to electrical failure (fatal arrhythmia), and 21.3% were due to myocardial rupture. The high percentage of myocardial rupture in our series is probably attributable to the patients' more advanced age.¹⁶

Six patients (13%) among the 47 that died in the hospital had non-transmural myocardial infarction.

TABLE 5.—Hospital deaths: type of M.I. related to outcome.
(47 Patients: 67 M.I.'s)

	NO. OF M.I.	FIRST M.I.*			REPEATERS*			TOTAL*		
		P.F.	E.F.	Rupt.	P.F.	E.F.	Rupt.	P.F.	E.F.	Rupt.
Transmural	53									
Non-Extensive	36	2	4	6	8	5	0	10	9	6
Extensive	17	6	3	4	2	1	0	8	4	4
Non-Transmural	10									
Non-Extensive	10	3	1	0	2	0	0	5	1	0
Extensive	0									
Unknown Location	4									
TOTAL	67	11	8	10	12	6	0	23	14	10

Mortality Rate:										
Among Hospital Deaths (47 pts.)								48.9%	29.8%	21.3%
Of entire population (317)						14.8%				
Of patients with one M.I. (235)						12.3%				
Of repeaters (82)						22.0%				

* Number of patients. P.F. = Pump Failure. E.F. = Electrical Failure. Rupt. = Rupture.

TABLE 6.—Long term deaths: type of M.I. related to outcome.
(46 Patients: 74 M.I.'s)

	NO. OF M.I.	FIRST M.I.*			REPEATERS*			TOTAL*		
		P.F.	E.F.	Rupt.	P.F.	E.F.	Rupt.	P.F.	E.F.	Rupt.
Transmural	60									
Non-Extensive	45	4	13	0	2	11	0	6	24	0
Extensive	15	0	9	0	1	2	0	1	11	0
Non-Transmural	5									
Non-Extensive	5	0	3	0	0	0	0	0	3	0
Extensive	0	0	0	0	0	1	0	0	1	0
Unknown Location	9									
TOTAL	74	4	25	0	3	14	0	7	39	0

Mortality Rate:										
Among Long Term Deaths (46 patients)								15.2%	84.8%	
Of followed group (254)						18.1%				
Of patients with one M.I. (185)						15.7%				
Of repeaters (69)						24.6%				

* Number of patients. P.F. = Pump Failure. E.F. = Electrical Failure. Rupt. = Rupture.

TABLE 7.—EKG location of M.I.'s.

LOCATION OF M.I.	TOTAL NO.	PERCENT	SURVIVORS		NON-SURVIVORS		RUPTURE	
			NO.	%	NO.	%	NO.	%
AS	107	54.3	67	25.4	40	23.4	5	41.7
A	70		32	12.1	38	22.2	1	8.3
AL	54		36	13.6	18	10.5	1	8.3
HL	5		3	1.1	2	1.2	1	8.3
I	85	41.8	53	20.1	32	18.7	4	33.3
I-L	97		64	24.2	33	19.3	0	
Site undetermined	17	3.9	9	3.4	8	4.7	0	
TOTAL	435	100.0	264	100.0	171	100.0	12	100.0

TABLE 8.—*Observed hospital cumulative mortality rate.*

TIME OF DEATH FOLLOWING ADMISSION	FIRST M.I.		REPEATERS		FIRST M.I. AND REPEATERS		64,505 CASES ⁽¹⁸⁾ AVERAGE PERCENT
	NO.	%	NO.	%	NO.	%	
1 day	13	44.8	11	61.1	24	51.1	47
7 days	24	82.8	17	94.4	41	87.2	(0-2 days) 82
14 days	27	93.1	17	94.4	44	93.6	
21 days	29	100.0	18	100.0	47	100.0	100.0

TABLE 9.—*Long term (post hospitalization) mortality rate.*

TIME	KAISER FOUNDATION HOSPITALS		REPEATERS FROM OTHER HOSPITALS		KAISER FOUNDATION HOSPITALS AND REPEATERS FROM OTHER HOSPITALS		NATIONAL AVERAGE (2-12)	
	NO.	%	NO.	%	NO.	ANNUAL CUMULAT.	ANNUAL CUMULAT.	
1 year	19	9.7	6	22.2	25	10.4	17.7	
2 years	11	5.6			11	4.6	7.3	
3 years	3	1.5	3	11.1	6	2.5	4.8	
4 years	7	3.6	1	3.7	8	3.3	14.4	
5 years	2	1.0	1	3.7	3	1.2	22.0	1.1
6 years	2	1.0			2	0.8	10.2	45.3
7 years	1	0.5			1	0.4	23.2	6.9
8 years							5.0	67.4

Five of these died of pump failure. However, there was no patient with myocardial rupture noted among the patients with non-transmural myocardial infarction.

Of the 46 patients who survived the initial or recurrent myocardial infarction, and who were followed on an outpatient basis, 15.2% succumbed from pump failure; 84.8% from electrical failure or so-called "sudden death" (Table 6). "Sudden death" is probably due to ventricular fibrillation.¹⁷ The prevention of sudden death after the acute stages of myocardial infarction, following dismissal from the hospital, is most challenging and difficult.

The location of myocardial infarction does not seem to be correlated with the prognosis. No significant difference in survival rates between those with anterior and inferior myocardial infarction could be found in our study.

The incidence of anterior myocardial infarction (including anteroseptal, anterior, high lateral and anterolateral) was 54.3%. Inferior myocardial infarction (including inferior, inferolateral and strict posterior) occurred in 41.8%. Site was undetermined in 3.9% (Table 7).

Half of our hospital deaths occurred within the first 24 hours, 87% within the first seven days. These findings are comparable to larger series studied by PAS¹⁸ (Table 8). Our cumulative mortality at the end of the fifth year was 22% as

compared with 45.3% in other series (Table 9).

SUMMARY

Three hundred seventeen cases of acute myocardial infarction were studied and 254 cases with long term follow-up were summarized. The average hospital stay was 23.7 days during acute episodes.

Thirty seven per cent of patients with acute myocardial infarction were below 50 years of age and 69.7% were below 60 years of age. Caucasians accounted for 63.7%.

Since we did not have the incidence of patients with myocardial infarction in different ethnic groups among existing major hospitals on Oahu, we were not able to draw a final conclusion on the ethnic predilection in the incidence of myocardial infarction. From our present analysis, we have found Caucasians suffering the highest percentage of myocardial infarction among all ethnic groups.

Half of the hospital mortality occurred within 24 hours, and 87% within seven days following admission.

Hospital mortality in patients with the first acute myocardial infarction was 12.3%, and 22.0% in repeaters. The average mortality was 14.8%.

Pump failure occurred in 48.9%, electrical failure in 29.8%, and myocardial rupture in 21.3% of the hospital deaths. On the contrary, pump failure accounted for 15.2%, electrical failure for 84.8%,

and myocardial rupture for none of the deaths in long-term follow-up category.

The cumulative mortality at the end of the first year, exclusive of hospital deaths, was 10.4%, and at the end of the fifth year was 22% in our series. In larger series elsewhere the first year cumulative mortality was 17.7%, and fifth year cumulative mortality was 45.3%.

The reasons for lower cumulative mortality in our series cannot be ascertained at present. Willingness to hospitalize patients earlier and ability to identify mild cases may be possible explanations.

We feel our mortality compared favorably with

the national mortality figures in a pre-coronary-care-unit setting.

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*Do not think too much of the dignity of your profession,
Or of what it is beneath you to do.
It is a moral disorder of young nurses and,
I may add, of young doctors.*

—SILAS WEIR MITCHELL, M.D.

These two tests may provide earlier warning of impending rejection of a transplanted kidney.

Urinary C-Reactive Protein and Lysozyme in Renal Homotransplantation

A Preliminary Study

PATRICK K. C. CHUN, B.A., LIVINGSTON WONG, M.D., YOUNG K. PAIK, M.D.,
ARNOLD W. SIEMSEN, M.D., and YOSHITSUGI HOKAMA, Ph.D., *Honolulu*

C-reactive protein (CRP) and lysozyme analyses were done in five patients following renal homotransplantation. Levels of serum lactic dehydrogenase (LDH), sodium (Na), blood urea nitrogen (BUN), creatinine, urine alkaline phosphatase, creatinine clearance, urine volume and urine protein, were also determined. Urine CRP appeared only when an acute rejection crisis occurred. Similarly, lysozyme values increased only during acute rejection. The data suggest that examination of urine for CRP and lysozyme would help recognize acute kidney rejection crisis and enhance regulation of immunosuppressive therapy.

IN PATIENTS undergoing surgery, C-reactive protein (CRP) has been known to appear consistently in the serum 12-18 hours after the operation.¹ Furthermore, CRP persisted in the serum for at least four days and its intensity was found to be dependent on the severity of the operation.² Del Fabbro and co-workers³ noted in 30 patients with various forms of glomerulonephritis that CRP was present in both the serum and urine. In addition, Mukhin and co-workers⁴ noted that the appearance of CRP in the urine occurred with a minimal proteinuria threshold of 0.0066 g/100 ml. In individuals with hematuria without proteinuria, they found no CRP in the urine despite its high concentration in the serum.⁴ Crockson *et al*⁵ concluded that CRP was unique in being undetectable in normal sera but appears consistently

in the acute clinical phase following surgical trauma; they felt that CRP was therefore probably the most satisfactory single screening measurement for indicating occurrence of an acute phase clinical response post surgery.

Thus, on the basis of the foregoing, and realizing need for definitive procedures that would aid in predicting kidney rejection crisis, this study was undertaken, with the following purposes: (1) to examine urine CRP; (2) to compare urine CRP with other parameters, ie, serum LDH, Na, BUN, creatinine, urine alkaline phosphatase, creatinine clearance, urine volume, protein urea, weight, and during azathioprine and methylprednisolone therapy.

Several investigators have noted an increase in urine lysozyme activity in patients with a variety of kidney diseases.^{6, 7, 8} Osserman⁹ indicated that lysozyme was normally present in serum and was absorbed by the proximal convoluted tubules in the kidney. In general, lysozyme was absent from urine, but if present, the amounts ranged from 1 to 4 micrograms per ml in patients without evidence of renal disease. It was noted that lysozyme was released from the kidney into the urine following damage to the proximal tubules, as in cadmium poisoning and renal homograft rejection reactions.^{9, 10} The foregoing findings suggest urine lysozyme as another possible indicator of kidney rejection crisis. This study presents the analysis of CRP and lysozyme as indicators for evaluating kidney rejection crisis.

MATERIALS AND METHODS

Information on the five patients who underwent renal homotransplantation is presented in Table 1.

From the Department of Pathology, School of Medicine, University of Hawaii, Honolulu, Hawaii 96822, and the Institute of Renal Diseases, St. Francis Hospital, Honolulu, Hawaii 96817.

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Reprint requests to Dr. Y. Hokama, Department of Pathology, School of Medicine, University of Hawaii, Honolulu, Hawaii 96822.

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TABLE 1.—Summary of the Information including Clinical Diagnosis, and Date of Renal Homotransplantation are Scored for the Five Patients Studied.

CASE	AGE	SEX	DIAGNOSIS	RENAL TRANSPLANT (DATE AND DONOR)	REMARKS
1	26	M	Chronic Renal Disease	July 24, 1971 Sister	Kidney rejected March 25, 1971
2	50	W	Chronic Renal Disease	July 29, 1971 Donor	No complications
3	29	M	Chronic glomerulonephritis; hypoplastic left kidney	August 9, 1971 Brother	
4	19	M	Chronic glomerulonephritis	January 4, 1971 Mother	Expired, April 10, 1971 Bronchopneumonia, acute duodenal ulcer (hemorrhage)
5	36	M	Chronic glomerulonephritis	January 14, 1971 Brother	

Urine Examination for CRP and Lysozyme by Radial Immunodiffusion

Urine samples were collected and kept at -20°C until ready for examination.

CRP determination was carried out by radial immunodiffusion employing horse anti-CRP antiserum (HCRPA) obtained from Hawaii Immunological and Biological Laboratory, Kailua, Hawaii. Purified CRP was prepared by method of Hokama and co-workers.¹¹ Agarose plates were prepared by mixing 5.0 ml HCRPA with 25 ml of a 2.0% suspension of agarose at 50°C . The HCRPA-agarose mixture was gently mixed and dispensed in 3-ml aliquots into sterile 4-cm-diameter plastic petri dishes. Following solidification of agarose, standard wells of 3 ml diameter were made. Standard CRP was examined in parallel with each group of urine samples and the standard values were plotted (diameter of precipitate vs. concentration of the standard). The values of the urine samples thus obtained were interpolated from this standard curve over the standard range examined. The results were scored as millimeters in diameter of precipitate.

Lysozyme assay was carried out by radial diffusion. A 1.5% agarose (W/V) suspension was prepared in 100 ml of 0.05 M phosphate buffer, pH 6.1, and containing 0.02 M sodium chloride. To a standard preparation of *Micrococcus lysodeikticus* was added 10 ml of distilled water. This standard bacterial suspension was then added to 90 ml of the 1.5% melted agarose at 50°C . After thorough mixing, 3 ml were pipetted into each 4-cm-diameter plastic petri dish. After solidification overnight, the plates were ready to be used. Seven evenly spaced (1 cm) 3-mm-diameter wells were punched into the agarose. Egg white lysozyme in 4 to 40 $\mu\text{g/ml}$ concentrations were then added to each punched-out hole. After four hours at room temperature, the diameter of the zone of lysis was measured and a standard curve plotted.

A similar procedure was followed using the various collected urine samples of the five patients and the diameters compared to those of the standard curve to obtain the concentration of lysozyme. Standard *Micrococcus lysodeikticus* and egg lysozyme were obtained from Worthington Biochemical Corporation, Freehold, New Jersey.

Serum and Urine Clinical Chemistry

Serum and urine analyses were carried out with the SMA-12 Autoanalyzer in the Department of Pathology, St. Francis Hospital.

RESULTS

The results of urine CRP and lysozyme are compared with creatinine clearance, BUN, urine protein and serum creatinine during the course of azathioprine and methylprednisolone therapy. These data on the five patients are summarized in figures 1 through 5. The results of serum LDH, Na, urine alkaline phosphatase, urine volume and body weight were not scored in the figures, but are discussed in the results where pertinent relative to CRP and lysozyme.

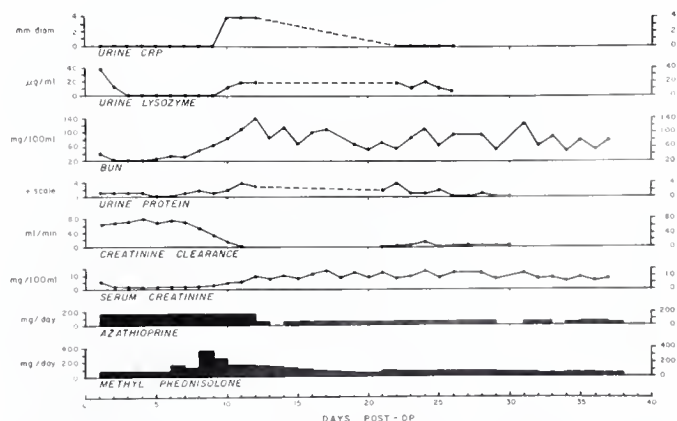


FIG. 1.—The results of CRP, lysozyme, BUN, urine protein, urine and serum creatinine analyses, and the therapeutic administration of azathioprine and methylprednisolone for Case 1.

In Fig. 1, the CRP, lysozyme, BUN, creatinine clearance, serum creatinine, and azathioprine and methylprednisolone therapy in the postoperative course of Case 1 are plotted. CRP appeared on the 10th day postoperatively, remaining elevated until the 12th day. Unfortunately, no urine was collected between the 12th and the 22nd days. There was significant increase in lysozyme activity on the first day after renal homotransplantation, dropping to normal levels on the third day. Subsequently, lysozyme activity showed a marked secondary rise on the 10th day post-op at the time of CRP appearance. Between the 22nd and 26th days post-op, a rise in lysozyme activity was still evident. Urine lysozyme, as compared with LDH, BUN, and alkaline phosphatase, exhibited less fluctuation during the patient's hospital course. A significant drop in the urine Na was noted on the sixth day after surgery, with a concomitant rise in BUN to 140 mg %. Kidney biopsy done on the 10th day revealed acute tubular necrosis, suggesting glomerular tubular imbalance. Corresponding to the appearance of CRP in the urine was a rise in the lysozyme, BUN, urine protein, and serum creatinine, and a fall in the creatinine clearance. Methylprednisolone dose was increased from 170 to 340 mg/day on the eighth day.

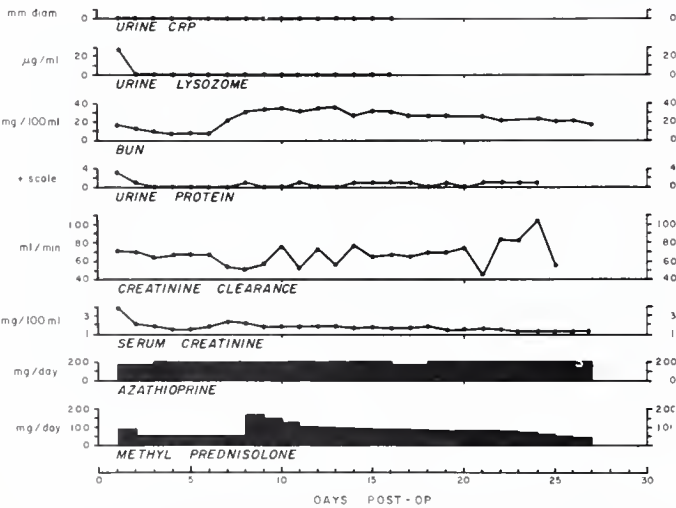


FIG. 2.—The results of CRP, lysozyme, BUN, urine protein, urine and serum creatinine analyses, and the therapeutic regimen of Case 2.

In Case 2, as depicted in Fig. 2, urine CRP remained negative with an initial elevation in lysozyme, as would be expected immediately after surgery. Other than an elevation in the creatinine clearance on the 10th day suggestive of an increase in kidney function, this patient's hospital course was essentially unremarkable. Urine CRP and lysozyme again, as compared with LDH, BUN, and alkaline phosphatase, exhibited less fluctuation during the patient's course. Urine protein after the second day post-op remained from 0 to 1+.

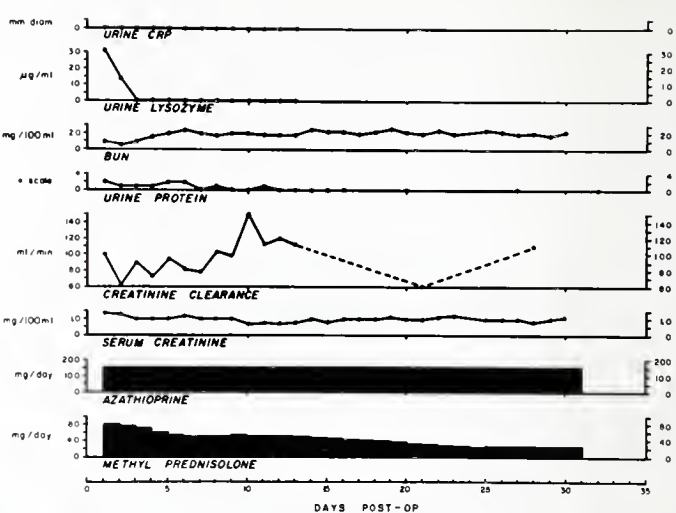


FIG. 3.—The results of CRP, lysozyme, BUN, urine protein, urine and serum creatinine analyses, and the therapeutic regimen of Case 3.

Patient 3, on the other hand (Fig. 3) appeared to have had a rejection crisis on the sixth post-operative day as indicated by a slight rise in BUN and serum creatinine, and a fall in creatinine clearance. Urine CRP was negative and no lysozyme was detected throughout this possible rejection crisis. LDH at this time showed a rise, whereas urine alkaline phosphatase and Na showed a decrease. A decrease in urine Na is supposedly common in patients with a rejection crisis of moderate intensity; in this patient, the fall in Na occurred concomitantly with relative oliguria. Decrease in Na excretion may be attributable to methylprednisolone therapy. Urine protein remained positive until the day of the crisis and appeared to fluctuate thereafter.

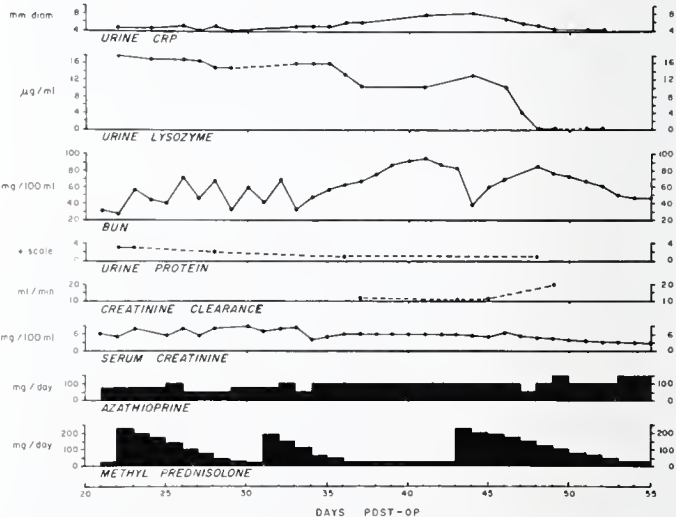


FIG. 4.—The results of CRP, lysozyme, BUN, urine protein, urine and serum creatinine analyses, and the therapeutic regimen of Case 4.

CRP and lysozyme in the samples of Case 4 were elevated between the 22nd and 47th days after surgery (Fig. 4). BUN was also elevated during this interval, but fluctuated widely between

the 21st and 33rd days. Methylprednisolone dose was increased and then reduced. Unfortunately, few values were obtainable for urine protein and creatinine clearance during this period.

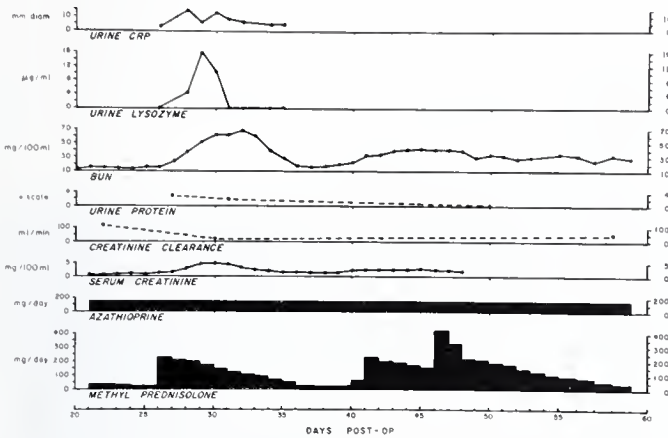


FIG. 5.—The results of CRP, lysozyme, BUN, urine protein, urine and serum creatinine analyses and the therapeutic regimen of Case 5.

In Fig. 5, representing the postoperative course of Case 5, appearance of CRP and a significant rise of lysozyme were noted with a corresponding rise in BUN and serum creatinine. Methylprednisolone dose was increased at this time, and again later, then tapered off.

DISCUSSION

Appearance of CRP in urine suggests an immediate abnormality in the kidney filtration system, since it is a high-molecular-weight protein.^{11, 12} Furthermore, since it is an abnormal protein, its appearance in urine five days after surgery would suggest a continuous inflammatory occurrence in the kidney or at the renal transplant site or elsewhere. Similarly, increase in urine lysozyme could denote either increased leucocytic infiltration or inefficient absorption by the convoluted proximal tubules of the kidney, since serum lysozyme is presumably reabsorbed at this site.

Thus, the measure of urine CRP and lysozyme in renal homotransplantation could be significantly utilized in the proper therapeutic management of transplanted patients. Our data appear to confirm the assumption that CRP and lysozyme measurement suggest real rejection phenomenon. The other parameters considered, serum LDH,¹³ Na,¹⁴ urine alkaline phosphatase, urine volume, and body weight appear to show greater fluctuations from day to day. Furthermore, persistent urine CRP or urine lysozyme suggest a poor prognosis and perhaps ineffectiveness of the therapeutic agents.

Our lysozyme data are compatible with those of Noble and co-workers⁶ and Shehadeh and co-workers,⁷ who have cited cases in which urine lysozyme increases occurred prior to BUN in an acute rejection crisis.

The fact that an acute rejection crisis is reversible with an increase in the dosage of steroids suggests the importance of determining when increase in therapy should be instituted. Regulation of the amount of steroid given, and the time it is given, is mandatory when the patient is highly susceptible to ulceration and to infectious agents. Urine CRP and lysozyme measurements should be considered as adjuncts to other parameters in determining the appearance of a rejection crisis, for by detecting the onset of rejection at the earliest moment, it may be possible to increase or decrease immunosuppressive therapy when necessary and thereby minimize the crucial side effects associated with the therapy.

We are indebted to the staff of St. Francis Hospital, Mr. Kazuto Yamada, and Miss Linda Wright for their technical assistance and cooperation.

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Benign hepatic tumors may have a malignant course.

Giant Hemangioma of the Liver

MANUEL ANG, M.D.,* and ROY TANOUE, M.D., *Honolulu*

A massive asymptomatic hemangioma of the liver was found by palpation, evaluated by scan, and diagnosed by biopsy at laparotomy.

A 53-YEAR-OLD Japanese man, born on Kauai, was admitted for the first time to Kuakini Hospital on March 8, 1971, for evaluation of an asymptomatic upper abdominal mass noted on physical examination 16 days before. Except for the mass, there were no gastrointestinal symptoms, fever, or chills. Patient had not seen a physician for the last 20 years. No history of jaundice. He had never been out of Hawaii nor received a blood transfusion.

On physical examination, the patient was a healthy-appearing man with a palpable liver, extending 2 inches below the costal margin in the right anterior axillary line, 4 inches below in the right midclavicular line and 1 inch below in the midsternal line. The liver was smooth, nontender, and noncompressible, and the liver edge was sharp. No bruit or thrill could be heard over the mass.

Hemoglobin was 12.5 gm/100 ml., hematocrit 37%, WBC and differential within normal limits. Urine was clear, with specific gravity of 1.010 and RBC of 6-8/hpf. Prothrombin level was 100%, patient 11.5 sec. and control 12.0 sec. FBS was 99 mg%, BUN 14 mg%, uric acid 5.8 mg%, cholesterol 262 mg%, albumin 4.4 gm%, globulin 2.3 gm%, SGOT 32 units, alkaline phosphatase

42 units. Alpha fetoglobulin test was negative with 2 different antisera in agarose immunodiffusion.

Plain x-rays of the abdomen, barium enema, upper GI series, and gallbladder series were normal except for marked hepatomegaly and a 5 mm calcification at the gallbladder area. Liver scan using radio Tc 99 m sulfur colloid (Fig. 1) revealed almost all the substance of the right lobe of the liver to be occupied by a large filling defect with massive liver enlargement, suggesting a large space-occupying lesion.

Sigmoidoscopy and biopsy showed an adenomatous polyp at 10 cm.

At laparotomy, both lobes of liver were markedly enlarged. In the right lobe there was a 15 x 12 x 10 cm mass occupying the anterior portion. A fibrous capsule appeared to surround the mass anteriorly. From a biopsy at the edge of the reddish brown granular lobulated soft surface, a hemangioma was found on frozen section. The patient had an uneventful postoperative course and was discharged on the seventh postoperative day.

LITERATURE REVIEWED

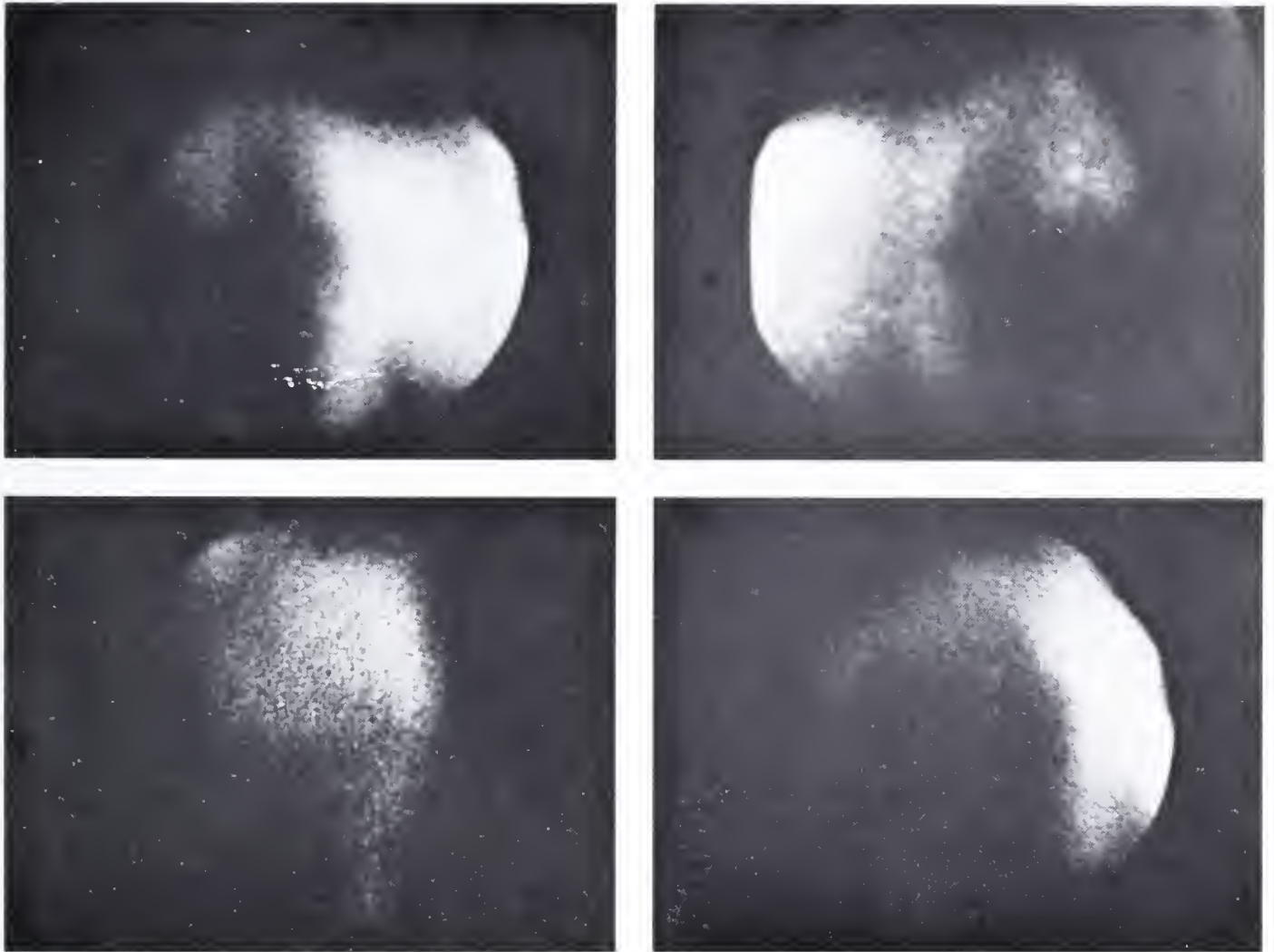
Hemangiomas are the most common benign tumors of the liver. According to Geschickter and Keasbey,¹ hemangiomas are found more often in the liver than in any other intestinal organ. They are usually an unexpected discovery at necropsy or laparotomy, more common in the left lobe than the right lobe,⁴ and are found at all ages, but especially common in the third, fourth, and fifth decades of life.

Kuakini Hospital and Home.

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FIG. 1.—Liver scintiphoto with Tc-99m sulfur colloid in four projections, showing massive hepatomegaly with almost all the right lobe of the liver occupied by a large filling defect suggestive of a space-occupying lesion.



Hepatic hemangiomas are more common in women than in men. The predominance in women under 40 is thought to be related to pregnancy. The hemangiomas may enlarge rapidly during pregnancy. Sewell and Weiss³ reported a case of spontaneous rupture in a 4-months-pregnant woman.

In infants, such a lesion may involve the whole liver and enlarge progressively during the first six to 12 months of life. After a variable time it may remain stationary.

Though usually solitary, hepatic hemangiomas may be multiple, as small as a pea, or as large as a child's head, according to Ribbert.⁵ The gross consistency of the tumors varies from cystic and soft to firm and hard, or may be a solid mass.⁶ A

fibrous capsule may be found. The color may be reddish brown to purple.

These hemangiomas are practically always of the cavernous type. Microscopically irregular endothelial-lined spaces are filled with blood. Intravascular thrombosis or rupture of channels may alter the pattern, creating large masses of fibrous tissue laden with hemosiderin pigment.

Symptomatic massive hemangiomas are uncommon.⁶ The most common presentation is a self-detected upper abdominal mass diagnosis, but there may be diffuse abdominal distention. Physical examination will reveal a soft, well-delineated, at times compressible mass. Rarely, a thrill may be detected. Space occupying signs may suggest gallbladder, pancreatic, splenic, or gastric tumors.

The patient may present in shock if rupture has occurred. In newborn infants, sizable cavernous hemangiomas of the liver have been found prone to early rupture, and Clatworthy *et al*⁷ consider such lesions a surgical emergency. The main effect of these large and diffuse hemangiomata of the liver in infancy is to act as an A-V shunt; they can lead to a state of high output cardiac failure.

Plachta⁸ suggests the triad of hypertension, hepatomegaly of stony consistency, and characteristically arranged roentgen appearance of calcification within the liver may aid in diagnosis. The triad of cutaneous hemangiomatosis, hepatomegaly, and congestive cardiac failure, as suggested by DeLorimier,⁹ has a mortality of 80-90% when treated by the conventional methods.

Splenoportogram may show liver defects corresponding to an angiomatous mass which might compress portal or splenic vein. Hepatic scans are particularly useful. It is suggested that, in addition to using tagged colloidal gold or rose bengal liver scans, the use of tagged human serum albumin, as used in placental scanning, may show areas of hyperactivity within a vascular mass. This may help identify the presence of hemangioma without having to resort to a liver biopsy.¹⁰ Selective hepatic arteriogram has sometimes been found to be useful by showing the "lake of dyes."

Hemangioma of the liver has been diagnosed by percutaneous needle biopsy without mortality, but there looms a real danger of fatal hemorrhage from such tumors, especially those situated on the liver surface.

METHODS OF TREATMENT

The two main methods of treatment are surgical and irradiation.

Tinker¹¹ in 1935 reported the first successful resection of a ruptured hemangioma. Indications for surgical treatment as suggested by Mercodier and Pernod¹² are rupture, intratumoral hemorrhage, and necrosis following segmental thrombosis (a very rare complication). Some hemangiomas are embedded in liver substance during early stages of development, but as they enlarge a pedicle of variable width may develop, through which the tumor receives its blood supply. In such cases, surgical excision is simple. Wedge resection may be done. Large tumors may be extirpated by planned hepatic lobectomy. For symptomatic giant hemangioma confined to one lobe, resection is the procedure of choice.¹³

Ligation of the common hepatic artery at the porta hepatis one inch distal to its origin has successfully alleviated the complication of cardiac failure from massive hemangiomatous involvement of both lobes of the liver.^{9, 14}

Irradiation may be used for nonresectable symptomatic hemangioma. Ray¹⁵ in 1939 gave the first report of successful irradiation of hemangioma of the liver. Success is gauged by relief of symptoms and arrest of growth rather than by regression of the tumor.

Another successful method of treatment, reported by Goldberg and Fonkalsrud,¹⁶ is the use of systemic corticosteroids in one patient with hepatic hemangioma occupying one-half of the liver volume.

SUMMARY

A case of giant hemangioma of the liver involving the right lobe of the liver is reported. Since the tumor was asymptomatic and extensive, no attempt at lobectomy was made. Patient did well following exploratory laparotomy.

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Our New President

William E. "Bill" Iaconetti, of Lahaina, took over the reins of the HMA in May, the first time in four years the job has gone to a neighbor island physician.

Bill is a good choice for the job, no doubt about it. Born May 10, 1924, in San Francisco, he had three years' service in the U. S. Navy before he graduated from the University of California School of Medicine in 1948. While at the University, he was president of the medical school student body and belonged to Nu Sigma Nu medical fraternity. He interned in Alameda, had four years of residency training in the East Bay, at Merritt and Highland Hospitals, and interrupted his residency training for two years' duty with the U. S. Air Force.

On August 6, 1956 he received Hawaii License 866 to practice medicine, and a numerologist ought to be able to make something good out of that. He joined the Maui Medical Group in 1958, in the field of general practice and general surgery.

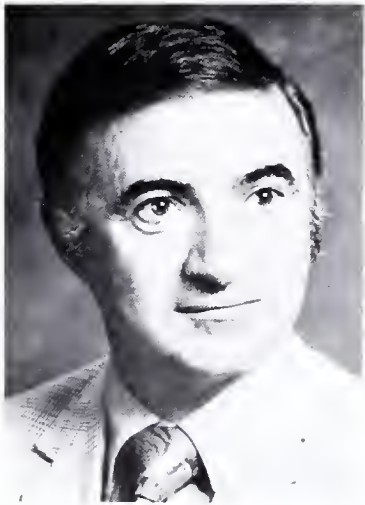
Bill was married in 1949 to Lorraine E. Olsen, of Berkeley, and they have had three children: Richard, 19, is at the University of Hawaii; Robert, 17, is in high school at St. Anthony's; and Lori, 10, goes to school in Lahaina.

Bill is a past president of the hospital staff at Maui Memorial Hospital, and was president of Maui County Medical Society in 1964. He has been an active member of several HMA committees in every calendar year since 1960, notably Medical Care Plans and Fees, and Federal Medical Services, and the ad hoc committee for the AMA's upcoming Clinical Session in Honolulu. He became president-elect in 1971.

Bill's hobby, an associate said, is his family; he does not devote his spare time to golfing, fishing, or shooting pool, but spends it with the children and his wife, at home, or, as now, traveling. However, we did learn that Bill enjoys a game of tennis occasionally and sails a little Sunfish.

His expertise in food and wine drew an admiring comment from one of the Hawaii delegation to the AMA meeting in San Francisco last month.

But the basic fact is that he is an energetic, conscientious, intelligent guy with a keen sense of responsibility as an organization man and a keen awareness of the problems of the general practitioner—and also the medical group. We confidently expect to be well served and well guided in the coming year.



The President's Page

A SURFEIT OF BUREAUCRACY!! The Hawaii Medical Association has recently expressed its concern nationally and locally over the high-handed manner in which the National O.E.O. offices have ignored community resources, desires and facts in granting to a large private enterprise massive federal funds to carry out a hastily developed proposal to establish three of its clinics in rural Hawaii.*

The request for these funds was conditionally granted to the private enterprise despite written opposition and/or concern from the community associations involved, from professional bodies and planning agencies, over inaccuracies and lack of community consideration and planning in the proposal. All local and regional offices were apparently by-passed in this bureaucratic maneuvering using the communities as pawns in a larger game.

The proposal was said to be initiated by the National O.E.O. office which found in March 1972 that it had extra funds which apparently needed to be spent by July 1, and contacted only Kaiser Foundation Health Plan, Inc. to ask if it would like to draw up a proposal by May 5.

The proposal was submitted in early May without any community or planning agency input, and while it has some good points, it makes inaccurate statements and implications which are misleading. Letters of protest and/or concern from the Community Associations, the Hawaii Medical Association, Honolulu County Medical Society, the Department of Health, Health and Community Services Council, and the local O.E.O. office were sent to the National and local O.E.O. offices and are in file. It was felt and stated that:

- (1) The community situation was misrepresented,
- (2) The community was not consulted,
- (3) Development of the proposal could seriously disrupt and undermine existing and developing medical services with which the communities seem pleased, and which are community oriented and planned,
- (4) Existing medical services by resident physicians in the area would be in jeopardy, as the Foundation Plan, Inc. proposed to take over DSS and OEO cases, with the Federal-OEO grant providing a very high per capita reimbursement to the private enterprise, and funds for them to build new clinics. The removal of these patients from the present practicing physicians' care will make it very difficult for the physicians to remain in the community in independent practice and, according to the proposal, they would be replaced by impersonal part-time physicians with nurse and health coordinator coverage between times.

HAWAII MEDICAL JOURNAL

A telegraphed message from the local O.E.O. office was sent to National offices on May 24, 1972 basically asking that the grant be held up until there was more time for community assessment. A letter from the local O.E.O. office followed this, being mailed from Honolulu on June 7.

Despite this united community and professional opposition, early on June 8, 1972, the National O.E.O. promised the funds to the Foundation Health Plan, Inc. if it could develop "community acceptance."

Announcing the conditional grant has caused Kaiser-Foundation Health Plan, Inc. to mount an extensive advertising campaign in Kahuku and Kahaluu which may well result in disruption of community designed programs of care with the duplication and undermining of the existing providers of services and current community planning. It is also now revising the inaccurate proposal which was used to obtain the funds.

The O.E.O. maneuvering is contrary to all elements of good planning and established policies. It is contrary to HEW Secretary Richardson's statement calling upon the health care "industry" to undertake planning "that best utilizes what we have, ends duplication, prevents waste, improves efficiency, and most emphatically, meets the health needs of the entire community." The community feels that if these funds were used to support existing projects, greater gains would be realized.

Hawaii Medical Association is expressing concern regarding this bureaucratic maneuver which uses massive federal funds to impose on small rural communities a potential monopoly of one type of medical care delivery with no planning or community consultation. The Association has emphasized that it has *no desire to express any opposition to Kaiser itself*, or Kaiser's extension into various communities *using its own resources*. It also realizes that some physicians with Kaiser may have had an incomplete knowledge of portions of the Health Plan (insurance) division's proposal. The main objectors to the proposal are the people in the communities concerned and HMA is in sympathy with the reasons for their objections.

William E. Leonard MD

* There is now some question as to how long negotiations have actually been in progress on a national level.

Editorials

Comprehensive Health Planning and the Workings of Government

The rumor circulating at the annual meeting of the Health and Community Service Council last June 8, that Kaiser would receive a \$1.1 million Federal grant under O.E.O., caused some consternation. And well it might, because the grant, along with some health education activities, was to set up two satellite clinics in Kahuku and Kahaluu, with \$517,490 dollars allocated to the clinics alone. Representatives of the area were understandably miffed because nobody had consulted them. The administrator of the Kahuku Hospital, which services the area 24-hours a day, could hardly look with favor on this competing subsidized favorite. The grant award and local opposition were reported in the Advertiser June 16.

There were no doctors present from the area who have invested their lives and resources to service the area. The phrase in the proposal which really hurt was this:

"A circuit riding physician will serve each clinic on a half-day basis since the population of Kahaluu and Kahuku are insufficient to support a full time doctor." There happen to be five practicing doctors in the area already.

In this day of Federally financed Comprehensive Health Planning, the cornerstone of which is supposed to be consumer input, and getting everybody together in the process, and including the indigent in the mainstream of health care, it is ironic that O.E.O. should highhandedly fund a specific provider to service a select group of indigents and non-indigents with complete disregard

of all planning efforts which have gone into the area.

From the standpoint of the Kaiser plan it is perfect. They are given tax funds to build their facilities to service their members plus a select group of indigents. The Health and Community Services Council has just published its Oahu Health Facilities Report. Among other things it:

1. (p. 8) "supports the concept of legislative controls pertaining to health facility construction."
2. (p. 10) recommends "that the Health Services Division be allowed to review all major (ie \$100,000 or more) capital expenditure programs proposed by hospitals and related health facilities."
3. (p. 102) recommends "that the Kahuku Hospital replace its non-conforming wing and at the same time expand its facility to accommodate any additional needs."

How the Health and Community Services Council and Comprehensive Health Planning will react to the O.E.O.'s grant will be interesting.

The average physician, beset with the 24-hour-a-day task of caring for patients, cannot possibly keep up with all the forces shaping our futures. This latest instance of branches of government ignoring each other's guidelines and activities is enlightening.

JOHN J. LOWREY, M.D.

Scalded Skin Syndrome Revisited

"He is also to blame who did not act to right a wrong."

In the July-August, 1966 issue of HAWAII MEDICAL JOURNAL an article appeared on Toxic Epidermal Necrolysis, a Case Report. In this article I made several statements that need correction in light of present day knowledge. In 1966, we did not know the etiology of this dermatosis of children that looks like a scalding. Lethal cases had

been observed and reported by others, and because of the similarity of this disorder to Stevens-Johnson syndrome, the use of corticosteroids was strongly recommended. My enthusiasm overflowed in this article, to the point of saying "corticosteroid therapy may be life-saving!"

I would now refer the reader to an excellent

article by Drs. Marian Melish and Lowell Glasgow in the May 14, 1970 issue of the *New England Journal of Medicine*. With great skill Drs. Melish and Glasgow firmly established by fulfilling Koeh's postulates, the etiologic role of Phage Group 2 Staphylococci in this clinical syndrome which they justly renamed the "staphylococcal scalded skin syndrome."

Further discussion about this syndrome and specific therapy recommendations are outlined in Dr. Melish's article in the June, 1971 issue of

Pediatrics. It is far from rare; since June, 1972, some six cases have been seen at Children's Hospital. Anti-staphylococcal antibiotics are the treatment of choice, with coverage against penicillin-sensitive and penicillinase-producing staphylococci until culture and sensitivity are available.

Not only are corticosteroids not recommended; they are contraindicated, except in the most unusual case of an extremely septic child in shock!!

SHARON J. BINTLIFF, M.D.

Library for Parents of Exceptional Children

The problems of the *Exceptional Child* have been, and are, being faced and challenged by more and more men and women in the field of special education; and the unique and equally complex problems facing the parents who love and live with these children are now also gaining attention. A great stride forward in this area has been the establishment and volunteer staffing of a unique Library for Parents of Exceptional Children on the sixth floor of the Queen Emma Building in downtown Honolulu, Hawaii. This new facility consists of three small, bright and attractive rooms containing a wide spectrum of media materiel.

A collection of 5,000 titles of print and non-print materials is the heart of this library which seeks to service the parents of Hawaii's more than 4,600 exceptional children. To date the Library/Media Center has cost \$35,000. Of this over \$25,000 has been spent on software alone including filmstrips, discs and tapes (both cassette and reel-to-reel) and sound film loops to help the parent help himself *and* the child. These materials were chosen to assist the parent in meeting the recreational as well as the *academic* needs of special children, as well as to offer professional literature on guidance, counseling and daily living concepts.

Due to fiscal constraints, the new facility is staffed completely by eight volunteer librarians, seven of whom are graduate students at the Library School of the University of Hawaii. Future plans call for permanent staffing by a Librarian, Library Assistant and Library Technician. The Library/Media Center is presently open daily, from 8:30 a.m. to 4:00 p.m.

With the cooperation and under the administration of the Teacher Assist Center, Office of Library Services, the volunteer librarians have assembled a slide/tape presentation on the goals and scope of the Library/Media Center which was premiered at the annual meeting of the Hawaii Library Association in April, 1972, at the Sheraton-Waikiki. Another volunteer librarian has designed and executed a three-fold brochure to inform parents of the Library, and a third has inaugurated a series of lectures to parent-teacher groups. It is anticipated that the new facility will be utilized by teachers and librarians in the state as another valuable resource center.

Since its recent opening, the Library/Media Center has been visited by 102 parents of exceptional children, 48 teachers of Special Education, and 200 graduate students in this area of education. The Center has also provided 1,300 pieces of software on loan to parents and teachers and 50 pieces of specialized equipment for utilizing such materials.

The Library/Media Center is a beginning attempt to answer the needs of the parents of exceptional children, and the response has been gratifying. Typical is the gratitude of a grandmother of a child who is normal but who was born to deaf parents so he had failed to advance in verbalization at the same rate as would a child with hearing parents. Now, the grandmother is able to borrow materials to personally help her grandson, and at the same time, study professional books and guidelines on the unique problems surrounding a home where parents are deaf and the child is normal.

Hawaii Academy of Family Physicians



... THE RICH GET RICHER,
THE POOR STAY POOR.

One of the main issues in the up-coming political campaigns focuses on what columnist Tom Wicker calls "the gross maldistribution of income and wealth that may well be the fundamental American social problem."

The Cambridge Institute's Upton-Lyons study that he quotes, shows that 10.4 million families in the top 20% of our population take in 40% of all the income, whereas the 10.4 million families that make up the bottom 20% take in only 2%. And, interestingly enough, governmental subsidy in one form or another has not narrowed this gap significantly, all the hullabaloo against the rising tide of welfare payments to the contrary notwithstanding. As for wealth, rather than income, the top 20% own three times more than the remaining 80% all put together. If, as is claimed, this breeds rising social tensions, then perhaps therein lies the major cause of increasing rates of crime, of alcoholism, of drug addiction, and of violent rebellion. Figures prove that this gap between rich and poor has been widening over the past 25 years.

What might this mean from a medico-socio-economic point of view? Perhaps the seemingly paranoid push for nationalization of health care is just another symptom of the "money gap" disease. What has been done about it? Very little.

When the Congress granted the benefits of MEDICARE to the elderly among us, it did so with largesse distributed equally to rich and poor. The precedent for this had been set years before by the laws on social security. The cost of this largesse to the ordinary taxpayer has turned out to have exceeded by far the actuarial prognoses made at or before the enactment of the laws. Such lavish programs are now becoming apparent as a major burden on the middle-income and lower wage earners particularly. This country is indeed affluent, but not affluent enough to provide welfare benefits to the rich as well as the poor.

At one time in the past it was charity that bridged the gap. In the realm of medical care this was translated into free service offered by doctors and hospitals. Now that the government has taken over via MEDICARE and MEDICAID, it has not only discovered that the oldtime charity had a greater value in dollars and cents than was then admitted, but that the tax dollar the government

takes cannot provide the benefits needed to bring the health of the poor up to levels acceptable to the nation.

Senator Edward Kennedy *et al* claim that by improving the health of the poor, the problem of poverty will be resolved (the exaggerated impact of that statement is theirs!). However, wiser voices are being heard in the national debating chambers—that of the American Medical Association among them—and these point out the error of putting the cart before the horse. Once the poor and near-poor have ready access to proper nutrition, housing and education, the improvement in their health, with a little help from us physicians and our paramedical siblings, will become manifest.

If we grant, then, that those who can now afford the top-quality medical care that is available in this country are NOT a part of the problem, then let us not waste time trying to upset the whole medical care system in order to solve what is THE problem: The health needs of the ten million families in the lowest economic bracket of our population.

Taxpayers do not grumble as a whole if they are satisfied that their precious tax dollars are well-spent. If the government's charitable programs (welfare, medicare, medicaid, ADC, etc.) were directed according to need, were efficiently managed, and were protected from abuse, the people would accept reasonably the burden, which is the charitable assistance to the less fortunate in our midst. What the people do NOT want is for their government to redistribute the wealth it has obtained from them by punitive taxation which reduces their level of living—passing it around with political overtones to the rich as well as the poor, to the undeserving as well as the truly needy.

In this regard, our AMA's "MEDICREDIT" plan would go further towards resolving the problem of maldistribution of medical care than any National Health Plan or HMO. However, we still need to devise something specific for our profession to contribute to the care of the poor—something embodying true charity, the spirit upon which the society of man is based. The organizations of medicine need to put their minds to this.

J. I. FREDERICK REPPUN, M.D.

The New Learning

With talk of university campuses in revolt, faculty members insulted, and emotionally immature students demanding the right to decide what they should learn and by whom it should be taught, it is time, perhaps, to try once again to define the true meaning of learning and what we hope to gain from it. Leon Eisenberg writes (*Science*, 1972 176:123):

"It may have sufficed in the past to spur a child to learn for the sheer satisfaction of his own success. If we have listened to what our students are telling us, [we know that] learning for personal embellishment or for the acquisition of virtuosity no longer satisfies a generation intensely aware of injustice and impermanence. Learning must become a social enterprise, informed by concern for others. This it can become. Man is his own chief product. The infant who discovers that he can control the movements of his own fingers transforms himself from observer into actor. The child who masters reading unlocks the treasury of the world's heritage. The adolescent who insists upon a critical reexamination of conventional wisdom is making himself into an adult. And the adult whose concerns extend beyond family and beyond nation to mankind has become fully human. By acting on behalf of our species we become men and women. In a world in which wars rage, in which repressive governments subjugate their peoples, in which the pursuit of personal affluence ravages an environment that must be shared by all, there can be no neutrality."

His message, which seems particularly pertinent to medical education, is that learning today must be relevant to current social problems and show concern for the welfare of others if it is to be a meaningful and fulfilling experience.

The UCU

A prevailing trend in present day medical practice is the establishment of specialized units to manage specific problems. Such examples as the ICU, CCU, SIU, and Renal Dialysis unit come readily to mind. Now Dr. Samuel Vee, of Canada, has made another giant leap forward in the eternal

struggle to relieve suffering humanity by establishing the Urinary Care Unit. He writes (*JAMA*, Feb. 28, 1972):

"There is much ado about coronary care units. No one would dispute their life-saving potential. But the wide publicity accorded these establishments tends to obscure other, less dramatic, developments in the realm of public-health-care-and-comfort-delivery, such as the urinary care units (UCU), which have been in operation in our town for well over a year. We have set up these units at strategic corners of our business district, and in a few suburban shopping centers. Not to be confused with Parisian kiosk, or the traditional Calcutta Catheter Clinic, nor with restrooms wherein neither the elderly victim of prostatism nor the young sufferer from stricture finds rest, the urinary care unit provides comfort, first aid, and psychotherapy. The units are well equipped with catheters, sounds, and dilators, and are staffed with competent nurses well trained in providing immediate relief, comfort, and psychiatric reassurance.

"A modest fee of \$1 is charged per visit, with reduced monthly or yearly rates available. Such are the benefits of the UCU, that none of the clients feels that he is passing [*sic*] away his money."

Fit to be Tied

The specter of overpopulation and starvation which overhangs the brave new world of the future has made the problem of birth control one of the burning social issues of our time. Men are constantly being urged, by physicians and public organizations alike, to have a vasectomy: the modern, safe, and simple method of contraception. Some of these organizations will even reward the hapless victim of this surgical assault with a cute and symbolic tie tack or lapel button which proclaims to the world that he is now safe and harmless, rather like a neutered tomcat.

The possible long-term consequences of this dangerously simple operation, apart from the most obvious one of sterility, are rarely discussed with the patient beforehand. So that truly informed consent may be obtained prior to performance of this

continued page 344

★Respiratory Physiology, 2d Ed.

Edited by Balfour N. Slonim and Lyle H. Hamilton, 229 pp., \$10.75, C. V. Mosby Co., 1971.

AN EXCELLENT, up-dated review of modern applied respiratory physiology for the practicing clinician as well as a clear, concise presentation to the student who is new to the field. Basic principles are expressed in terms of dynamic physiologic concepts and supporting data, which makes the approach more appealing and understandable to those concerned with clinical application. This text, therefore, would also serve as a good reference to turn to in solving practical clinical problems in basic gas and respiratory physiology.

There is meaningful development of the fundamentals required to properly understand the clinical interpretation of the various tests of pulmonary function described, and the book thereby becomes an appropriate precursor to other texts which deal more clinically with diagnostic evaluation and managements of various disorders of respiratory function.

PHILIP R. FOTI, M.D.

The Pediatric Nurse Practitioner

By Fernando J. deCastro, M.D. and Ursula T. Rolfe, M.D., 154 pp., \$6.50, C. V. Mosby Co., 1972.

THE PREFACE says "this is . . . intended as an outline for nurses who wish to expand their empirical knowledge of ambulatory pediatrics." It is also intended as a guide for recent Pediatric Nurse Practitioner graduates. The book is divided into three main sections: Health Appraisal, Clinical Problems and Social Problems.

In my opinion, the book has little to offer in that the sections were not covered comprehensively enough to be of much value to a nurse. The only chapter that appeared of value is the one on "Medical History" under Health Appraisal. There was enough detail to offer aid to any nurse who has not had any experience in taking medical histories. None of the other topics are developed enough for this text to be of use for any nurse practitioner. Perhaps its best function is as a brief guide for anyone interested in knowing what is to be covered in the curriculum of a Pediatric Nurse Practitioner.

BETTY S. M. SOO, M.D.

Etiology and Prevention of Cancer in Man

By E. V. Cowdry, M.D., 420 pp., Appleton-Century-Crofts, 1968.

AN EXCELLENT SOURCE of information on the etiology and prevention of the important tumors of man. It is of very significant value to the beginning student as well as the advanced oncologist.

GROVER H. BATTEN, M.D.

★Pediatric Therapy, 4th Ed.

Edited by Harry C. Shirkey, M.D., 1221 pp., C. V. Mosby Co., 1972.

THIS VOLUME, edited by our erudite friend Harry C. Shirkey, is a compendium of modern pediatric therapy. The contributing authors are all leaders in the pediatric field.

The book is beautifully organized and exhaustive in its coverage. Not only medicinal therapy but all other forms of therapy are included. It should be available for reference in all hospitals and clinics where children are treated.

DONALD C. MARSHALL, M.D.

Current Concepts in Dyslexia

Edited by Jack Hartstein, B.S., M.D., 212 pp., \$12.00, C. V. Mosby Co., 1971.

THIS BOOK should be in the library of every physician who sees children with any reading problem: pediatricians, family doctors, neurologists, psychiatrists, ophthalmologists, internists. It gives complete information regarding reading problems in children and the proper advice to give to parents.

Numerous authors have contributed to this book; educators, pediatricians, neurologists, ophthalmologists, orthopedic technicians, directors of centers for treatment of learning disorders, psychologists, psychiatrists.

HERBERT G. PANG, M.D.

★ means highly recommended.

Proceedings of
The House of Delegates



116th Annual Meeting
May 9-12, 1972

116TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

HONOLULU, HAWAII

May 9-12, 1972

The annual meeting for the one hundred and sixteenth year of corporate existence of the Hawaii Medical Association was held in Honolulu in 1972. The following program was presented.

SCIENTIFIC PROGRAM

PAPERS

The Panorama of Hepatitis, Viral and Other

Edward A. Gall, M.D.

The Pathogenesis of Cirrhosis

Edward A. Gall, M.D.

The Fibrinolytic Function of Eosinophils and

Their True Role in Allergy

John W. Rebuck, M.D., Ph.D.

Laboratory Service to the Patient on Admission

Harry H. Marsh, M.D.

Tumors of the Head and Neck—Case Presentations

William O. Russell, M.D., Carl W. Boyer, Jr., M.D.,

Edward L. S. Jim, M.D., John P. Keenan, M.D., Hideo

Oshiro, M.D.

Liver Biopsy in the Evaluation of Neonatal and

Infantile Obstructive Jaundice

Jay Bernstein, M.D.

Emergency Room Toxicology

Harry H. Marsh, M.D.

The Contributions of the Necropsy to Medical Progress

Edward A. Gall, M.D.

Renal Insufficiency in the Newborn

Jay Bernstein, M.D.

New and Old Diseases of the Basophils and

Mast Cells, Ulcerative Colitis, Hunner's Ulcer,

Penicillin Sensitivity and the Mucopolysaccharidoses

John W. Rebuck, M.D., Ph.D.

Laboratory Diagnosis of Anemia

Harry H. Marsh, M.D.

Ultrastructural Diseases of Platelets, A Common Cause

of Unexplained Bleeding in Everyday Practice

John W. Rebuck, M.D., Ph.D.

Renal Biopsy in the Idiopathic Nephrotic

Syndrome of Childhood

Jay Bernstein, M.D.

Current Status on Antimicrobial Susceptibility Tests

and Their Utilization in Medical Practice

Harry W. McFadden, Jr., M.D.

Diagnosis and Treatment of Pulmonary Embolism

Harold L. Israel, M.D.

The Enigma of Asthma

Harold L. Israel, M.D.

Presidential Address

Herbert Y. H. Chinn, M.D.

AMA Presidential Address

Wesley W. Hall, M.D.

Selection of Antibiotics and Laboratory Monitoring of

Treatment in Subacute Bacterial Endocarditis

Harry W. McFadden, Jr., M.D.

Tuberculosis Revisited

Harold L. Israel, M.D.

Therapeutic Significance of Histologic Types of Primary Thyroid

Carcinoma: A Clinicopathologic Study of 777 Patients

William O. Russell, M.D.

Complications of Antimicrobial Therapy:—

Bacterial Resistance, Superinfections, and Toxicity

Harry W. McFadden, Jr., M.D.

Some Practical Aspects of Antimicrobial Agents and

Their Mechanisms of Action on Pathogenic Microorganisms

Harry W. McFadden, Jr., M.D.

What the Physician in Family Practice Needs

and Expects from the Pathologist

Marolyn M. Cowart, M.D.

Disease Patterns of the Japanese Migrant Population

Grant N. Stemmermann, M.D.

SOCIAL PROGRAM

Banquet, Pacific Ballroom, Ilikai Hotel

Sportsmen's Night, Natsunoya Tea House

MEETINGS

House of Delegates, Ilikai Hotel

Fireside Chats, Ilikai Hotel

Women's Auxiliary, Sheraton Waikiki

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Betty Soo (1972)
Hiroaki Tottori (1973)
Kirsten Vennesland (1972)
Calvin C. J. Sia, Commissioner
Walter E. Batchelder (Hawaii) (1972)
Katok A. Chuang (Kauai) (1973)
Joseph Andrews (Maui) (1974)

Crippled Children Committee

D. Venudhar Reddy, Chairman (1974)
Sharon Bintliff (1974)
Raymond Chock (1974)
George M. Ewing (1973)

William H. Gullledge (1972)
 George Henry (1974)
 Ivar J. Larsen (1973)
 Carl Lehman (1973)
 Robert Lindberg (1974)
 Alfred D. Morris (1972)
 Frances Nakamura (1973)
 Herbert Nakata (1973)
 L. Q. Pang (1971)
 Alan Pavel (1971)
 Jordan Popper (1974)
 Walton K. T. Shim (1971)
 John Smith (1974)
 Betty S. M. Soo (1972)
 Kazuo Teruya (1972)
 Coolidge S. Wakai (1971)
 John R. Watson (1971)
 Sorrell Waxman (1974)
 Raymond J. C. Wong (1974)
 Ronald Yamaoka (1973)
 Walter S. Yokoyama (1974)
 Calvin C. J. Sia, Commissioner
 M. L. Chang (Hawaii) (1972)
 Denis Fu (Maui) (1972)

Diabetes Committee

Willard Y. Miyahira, Chairman (1973)
 Anna Marie Brault (1972)
 David T. Eith (1973)
 Fred Goff (1973)
 Kleona Rigney (1973)
 Werner G. Schroffner (1974)
 Sorrell Waxman (1973)
 Rose K. L. Wong (1974)
 Calvin C. J. Sia, Commissioner
 Walter S. L. Loo (Hawaii) (1973)
 Robert Emrick (Kauai) (1974)
 A. Y. Wong (Maui) (1972)

Disaster Committee

Edmund C. K. Lum, Chairman (1974)
 Ralph Berry (1973)
 Roger Brault (1972)
 William Dung (1974)
 John Edwards (1974)
 Casimer Jasinski (1973)
 Isaac Kawasaki (1974)
 Robert F. Lindberg (1974)
 Joseph T. Lucas (1972)
 Mor James McCarthy (1974)
 Barry D. Miller (1974)
 Rodman B. Miller (1974)
 R. S. Pebley (1972)
 Millard S. L. Seto (1973)
 Garton Wall (1973)
 Daniel Whang (1973)
 Cesar De Jesus, Commissioner
 James K. Matayoshi (Hawaii) (1973)
 John N. Withers (Maui) (1972)
 Casper F. Rea (Kauai) (1974)

Environmental Health Committee

Leigh Sakamaki, Chairman (1972)
 Truett V. Bennett (1973)
 Roger Brault (1974)
 Thomas C. Brown, Jr. (1974)
 Cesar B. De Jesus (1972)
 Raymond Dusendschon (1973)
 Casimer Jasinski (1974)
 James H. Johnston (1974)
 Charles S. Judd, Jr. (1972)
 Felis James Lafferty (1974)
 Wallace Loui (1974)
 Wilbur S. Lummis (1973)
 Laurence J. McCarthy (1974)
 Alfred Dyer Morris (1973)
 Robert W. Peyton, II (1974)
 Calvin C. J. Sia, Commissioner
 Helen Percy (Maui) (1974)
 Billie F. Strother (Maui) (1974)
 Thomas M. Mar (Hawaii) (1974)
 Charles Custer (Kauai) (1974)

Fee Survey Committee

Maurice W. Nicholson, Chairman (1974)
 Lydia K. Bolosan (1974)
 Clifford B. G. Chang (1974)
 William G. Davis (1972)
 Raymond deHay (1973)
 Takakazu Fukumura (1972)
 Ralph Hale (1973)
 Kiyoshi Inouye (1973)
 Carl Lehman (1973)
 Gail G. L. Li (1972)
 Laurence McCarthy (1973)
 Yoshio Oda (1974)
 Noboru Oishi (1973)
 L. Q. Pang (1973)
 Francis Soon (1973)
 Garton Wall (1973)
 Frederick B. Warshauer, Consultant
 Herbert Wong (1973)
 Allan H. W. Young (1972)
 Charles S. Judd, Commissioner

S. Kasamoto (Hawaii) (1972)
 Samuel R. Wallis (Kauai) (1973)
 Sakae Uehara (Maui) (1974)

Filipino Speakers Bureau

Quintin L. Uy, Chairman (1973)
 Manuel A. Abundo, Jr. (1973)
 Gloria N. Badua (1971)
 Mario P. Bautista (1973)
 Norberta Baysa (1973)
 D. R. Canete (1974)
 Amelia Jacang (1974)
 Corazon A. Manayan (1973)
 Buenaventura E. Realica (1972)
 Arturo F. Salcedo (1973)
 Cesar De Jesus, Commissioner
 Gonzalo Geroso (Kauai) (1973)
 Jose Romero (Maui) (1971)

Finance Committee

Thomas P. Frissell, Chairman
 M. J. AVECILLA (1972)
 Robert Chung (1973)
 William W. L. Dang (1973)
 Kiyoshi Inouye (1974)
 H. William Goebert, Jr. (1973)
 Theodore T. Tomita (1972)
 Robert Berry (Kauai County Treasurer)
 Albert Chun-Hoon (HMS Treasurer)
 Allan S. Takase (Hawaii County Treas.)
 John N. Withers (Maui County Treas.)

Health Manpower Committee

H. H. Chun, Chairman (1972)
 Elisabeth K. Anderson (1974)
 Jeanette Chang (1973)
 Edward Chesne (1974)
 Fred Gilbert (1974)
 Mary A. Glover (1972)
 H. Wm. Goebert, Jr. (1973)
 William H. Hindle (1972)
 Shigeru Horio (1974)
 Wallace Loui (1974)
 B. R. Mehta (1974)
 Clifford Mirikitani (1974)
 Robert H. Oishi (1974)
 Stephen H. Tenby (1974)
 Hau Ngoc Vu (1974)
 Cesar De Jesus, Commissioner
 Tokuso Taniguchi (Hawaii) (1972)
 Robert Emrick (Kauai) (1973)
 Joseph E. Andrews (Maui) (1974)

Heart Committee

Coolidge S. Wakai, Chairman (1973)
 Bernard W. D. Fong (1972)
 Unoji Goto (1973)
 George W. Henry (1972)
 Tung Kuang Lin (1974)
 Wallace W. S. Loui (1972)
 Richard T. Mamiya (1973)
 Rodman B. Miller (1971)
 George Nagao (1972)
 Frances Nakamura (1974)
 James Orbison (1974)
 Niall M. Scully (1972)
 Bernard Yim (1974)
 Calvin C. J. Sia, Commissioner
 Reginald S. Carvalho (Hawaii) (1972)
 Eugene Rames (Kauai) (1973)
 DeWitt H. Smith (Hawaii) (1973)
 Bertram A. Weeks (Maui) (1971)
 A. M. Pettler (Kauai) (1974)

Hospital Committee

Gordon Liu, Chairman (1974)
 Ralph B. Berry (1973)
 Fugate Carty (1974)
 Fred I. Gilbert, Jr. (1972)
 William H. Hindle (1973)
 Wallace Loui (1974)
 Carl Lum (1973)
 Harold Sexton (1972)
 Albert Shimamura (1974)
 Hau N. Vu (1973)
 Henry H. L. Yim (1974)
 Winfred Y. Lee, Commissioner
 Verne Adams (Hawaii) (1973)
 Clyde Ishii (Kauai) (1972)
 Clifford F. Moran (Maui) (1973)

Japanese Speakers Bureau

Hideo Namaki, Chairman (1973)
 Noboru Akagi (1972)
 Takakazu Fukumura (1974)
 Keiichi Goshi (1973)
 Mitsuo Hattori (1972)
 Toshihiko Kawasugi (1972)
 Wilfred Minatoya (1974)
 Harry Nakata (1974)
 Shigeo Natori (1972)
 Richard Sakimoto (1972)

Emiko Sakurai (1972)
 Fumiyo Sugimoto (1972)
 Perry Sumida (1973)
 Naomitsu Tajima (1971)
 John Takamura (1973)
 Kazushi Tanaka (1972)
 Yoshiki Ushiyama (1972)
 Margaret Yamasaki (1974)
 Henry Yokoyama (1973)
 Cesar De Jesus, Commissioner
 Theo. T. Oto (Hawaii) (1971)
 Kenneth K. Fujii (Kauai) (1972)
 K. Izumi (Maui) (1973)

Legislative Committee

George Goto, Chairman
 Richard K. Blaisdell (1972)
 Donald F. B. Char (1972)
 Clarence F. Chang (1972)
 H. H. Chun (1974)
 Cesar B. De Jesus (1972)
 David Eith (1973)
 Gerald Faulkner (1973)
 Calvin C. M. Kam (1973)
 Roy Kuboyama (1972)
 Richard K. C. Lee (1973)
 P. Howard Liljestrand (1974)
 Bal Raj Mehta (1973)
 James L. Mertz (1972)
 George H. Mills (1973)
 Clifford Mirikitani (1972)
 Noboru Oishi (1973)
 Walter B. Quisenberry (1972)
 Leigh Sakamaki (1974)
 George F. Schnack (1971)
 Charles W. Stewart (1973)
 Benjamin C. K. Tom (1974)
 Theodore T. Tomita (1972)
 Herbert Uemura (1973)
 Sau Ki Wong (1973)
 Clarence A. Wyatt, Jr. (1972)
 John Zelko (Hawaii) (1972)
 Kenneth F. Fujii (Kauai) (1973)
 Clayton A. Johnson (Maui) (1973)
 Clifford F. Moran (Maui) (1971)
 Sakae Uehara (Maui) (1973)
 John J. Lowrey, Past President

Maternal & Perinatal Mortality Study Committee

Ann B. Catts, Chairman (1973)
 Mauricio P. Bautista (1973)
 Murray Berger (1972)
 George Goto (1974)
 Martha Lou Hefley (1973)
 William H. Hindle (1973)
 Doris Jasinski (1974)
 John A. Krieger (1974)
 Eunice J. Larson (1974)
 Corazon A. Manayan (1974)
 Paul F. McCallin (1974)
 Bunzo Nakagawa (1973)
 Herbert M. Nakata (1972)
 John M. Ohtani (1972)
 Richard Y. Sakimoto (1974)
 Millard S. L. Seto (1972)
 Roy Smith (1973)
 Francis H. Soon (1973)
 Wayne Takemoto (1974)
 Francis M. Terada (1974)
 Theodore K. L. Tseu (1973)
 Sorrell H. Waxman (1971)
 James T. S. Wong (1973)
 Calvin C. J. Sia, Commissioner
 Paul J. Caldwell (Hawaii) (1971)
 K. K. Fujii (Kauai) (1974)
 E. F. Longworth (Maui) (1974)

Medical Care Plans

Benjamin C. K. Tom, Chairman (1972)
 Roger Brault (1974)
 Claude Caver (1973)
 William W. L. Dang (1973)
 Raymond M. deHay (1972)
 Richard W. Fardal (1974)
 Masato Hasegawa (1973)
 William H. Hindle (1974)
 Carl H. Lum (1974)
 Wallace W. S. Loui (1972)
 Paul McCallin (1972)
 Shigeo Natori (1972)
 Theodore T. Tomita (1972)
 Charles S. Judd, Jr., Commissioner
 William F. Spies (Hawaii) (1974)
 Yonemichi Miyashiro (Kauai) (1974)
 William E. Iaconetti (Maui) (1972)

Medical Education Committee

Glenn Kokame, Chairman (1974)
 E. R. Ballard (1973)
 Ralph Berry (1974)
 Sharon J. Bintliff (1973)
 Richard Blaisdell (1973)

Max G. Botticelli (1973)
Donald Char (1973)
Hing Hua Chun (1974)
Henry Fong (1974)
Raymond H. Fujikami (1973)
Lawrence H. Gordon (1972)
Ralph Hale (1973)
John A. Krieger (1972)
Ivar Larsen (1973)
T. K. Lin (1972)
Richard Mamiya (1974)
Bal Raj Mehta (1974)
Robert A. Nordyke (1972)
Ramon Sy (1973)
Patrick J. Walsh (1972)
Sorrell H. Waxman (1972)
Edward Yamada (1974)
Winfred Y. Lee, Commissioner
George Bracher (Hawaii) (1973)
E. H. Fell (Hawaii) (1973)
Frank Tabrah (Hawaii) (1973)
P. M. Cockett (Kauai) (1973)
Clifford Moran (Maui) (1973)
John F. Morris (Maui) (1972)

Medicine and Religion Committee

Francis H. Soon, Chairman (1973)
Clifford Chang (1974)
Noni Brar Koch (1973)
Ralph Hale (1973)
Peter Larm (1973)
Pershing Lo (1973)
R. Reginald Patterson (1974)
Robert W. Peyton (1972)
Barry D. Miller (1974)
Goonzo Yamashita (1973)
Cesar De Jesus, Commissioner
DeWitt H. Smith (Hawaii) (1973)
J. Mark B. Sowers (Maui) (1972)

Mental Health Committee

George F. Schnack, Chairman (1971)
William J. T. Cody (1974)
Charlotte M. Florine (1974)
Edward M. Furukawa (1974)
Michael F. Hase (1973)
Francis M. Ikezaki (1972)
Pershing Lo (1973)
K. Y. Lum (1973)
William H. Sage (1972)
Maurice Silver (1973)
Robert Weiner (1972)
Ronald Yamaoka (1973)
Calvin C. J. Sia, Commissioner
Jose Romero (Maui) (1973)
Joan J. Takeuchi (Kauai) (1972)
James A. Mitchel (Hawaii) (1974)

National Legislation Committee

L. Q. Pang, Chairman (1973)
Donald F. B. Char (1972)
Cesar B. De Jesus (1971)
David Eith (1973)
Bernard W. D. Fong (1972)
Masato M. Hasegawa (1974)
Richard K. C. Lee (1974)
Wilbur S. Lummis (1972)
J. I. F. Reppun (1973)
Theodore T. Tomita (1972)
George Goto, Commissioner
John Zelko (Hawaii) (1973)
Clifford Moran (Maui) (1972)
Albert Ley (Kauai) (1974)

Negotiating Committee

Chew Mung Lum, Chairman (1973)
Grover H. Batten (1974)
B. Allen Richardson (1973)
Theodore T. Tomita (1972)
Charles S. Judd, Jr., Commissioner
Paul Caldwell (Hawaii) (1973)
Walter S. L. Loo (Hawaii) (1972)
Samuel Wallis (Kauai) (1973)
Mamoru Tofukuji (Maui) (1974)

News Media Committee

Henry N. Yokoyama, Chairman (1973)
Harry Arnold, Jr. (1974)
John Ronald Brown (1972)
Claude V. Caver (1972)
Percival Chee (1974)
Doris Jasinski (1974)
Rowlin L. Lichter (1974)
Bal Raj Mehta (1972)
Alexander Roth (1971)
Stephen H. Tenby (1972)
Cesar De Jesus, Commissioner
Keith Nesting (Hawaii) (1972)
Robert Emrick (Kauai) (1973)
Clayton Johnson (Maui) (1973)
Clyde Rossberg (Maui) (1973)

Nominating Committee

Livingston Wong, Chairman
Ann B. Catts
William W. L. Dang
Winfred Y. Lee
John J. Lowrey
George Bracher (Hawaii)
Kenneth Fujii (Kauai)
Sakae Uehara (Maui)

Operation Pacific Committee

George Suzuki, Chairman (1972)
L. Clagett Beck (1971)
Edward W. Boone (1972)
Anna Marie Brault (1972)
John R. Brown (1973)
Claude V. Caver (1973)
Frederick A. Dodge (1972)
William H. Gullledge (1973)
William J. Holmes (1972)
William P. G. Jones (1973)
H. G. Lawson (1974)
Robert Lindberg (1974)
Paul McCallin (1972)
Robert W. Peyton (1973)
Thomas H. Richert (1973)
Nathan Shklov (1973)
Francis M. Terada (1972)
Kazuo Teruya (1974)
Benjamin C. K. Tom (1972)
Garton Wall (1973)
Cesar De Jesus, Commissioner
Katok Chuang (Kauai) (1972)
G. S. Haywood (Maui) (1974)
R. P. Wipperman (Hawaii) (1974)

Pharmacy Committee

Lawrence Y. W. Wong, Chairman (1974)
Ralph B. Berry (1971)
Elmars M. Bitte (1973)
John F. Chalmers (1973)
Frederick S. F. Lee (1972)
Daniel D. Palmer (1974)
Walter H. K. Watt (1974)
Allan H. W. Young (1974)
George Goto, Commissioner
Reginald S. Carvalho (Hawaii) (1972)
Joan Takeuchi (Kauai) (1973)
Seiya Ohata (Maui) (1974)

Professional Liability Committee

Alan Pavel, Chairman (1972)
William W. L. Dang (1973)
Bernard W. D. Fong (1973)
George Goto (1972)
John J. Lowrey (1972)
Frank McDowell (1972)
Carolina D. Wong (1973)
George Goto, Commissioner
George Bracher (Hawaii) (1973)
Kenneth McCollum (Maui) (1973)
Ralph Berry (Kauai) (1972)

Public Relations Committee

Rowlin L. Lichter, Chairman (1972)
Harry L. Arnold, Jr. (1974)
John Ronald Brown (1972)
Claude V. Caver (1972)
Percival Chee (1974)
Raymond Fujikami (1974)
Robert Flowers (1973)
Gail Li (1974)
Forrest J. Pinkerton (1972)
Thomas Richert (1973)
George Schnack (1974)
Henry N. Yokoyama (1973)
Cesar B. De Jesus, Commissioner
William N. Bergin (Hawaii) (1971)
Charles Custer (Kauai) (1972)
J. Mark B. Sowers (Maui) (1973)

Publications Committee

L. Q. Pang, Chairman (1973)
Samuel D. Allison (1973)
Harry L. Arnold, Jr., ex officio
Herbert Y. H. Chinn, President
Thomas Frissell, Treasurer
Norman Goldstein (1973)
Meryl Haber (1972)
William Iaconetti, President Elect
Doris Jasinski (1974)
Frank McDowell (1973)
Arnold Siemsen (1974)
R. Varian Sloan, Secretary
K. S. Tom (1972)
Walter S. Yokoyama (1974)
Winfred Y. Lee, Commissioner
R. P. Henderson (Hawaii) (1972)
Kenneth K. Fujii (Kauai) (1973)
R. H. Moser (Maui) (1974)

Quackery Committee

William H. Sage, Chairman (1973)
Harry L. Arnold, Jr. (1974)
Robert C. Bell (1973)
Frederick A. Dodge (1971)
David Eith (1973)
Carl E. Johnsen, Jr. (1974)
Barry D. Miller (1974)
Kleona Rigney (1972)
Harry C. Shirkey (1972)
Francis H. Soon (1974)
Kazuo Teruya (1974)
Walter S. Yokoyama (1972)
Cesar De Jesus, Commissioner
Walter Batchelder (Hawaii) (1973)
Clifford Moran (Maui) (1972)
Charles Custer (Kauai) (1974)

Radiation Committee

Carl Boyer, Jr., Chairman (1973)
Harry L. Arnold, Jr. (1974)
Thomas C. Brown (1972)
Robert DiMauro (1974)
George W. Henry (1973)
Virgil Jobe (1973)
Philip Lee (1973)
Grover Liese (1973)
William J. Natoli (1973)
Robert G. Rigler (1972)
J. C. Wang (1972)
Calvin C. J. Sia, Commissioner
George Bracher (Hawaii) (1973)
Donald Dietrich (Maui) (1973)
Peter Claremont (Kauai) (1974)

School Health Committee

Roy Kuboyama, Chairman (1972)
Robert D. Bart (1973)
Donald F. B. Char (1972)
David T. Eith (1972)
Marv A. Glover (1972)
Amelia Jacang (1974)
Doris R. Jasinski (1974)
Felix J. Lafferty (1973)
Edward W. Lum (1974)
Donald Maruyama (1973)
George Murdock (1974)
Norman Nakamura (1972)
Michael M. Okiihiro (1974)
John H. Peyton (1972)
Roy Smith (1973)
Betty Soo (1974)
Stephen H. Tenby (1973)
Ronald Yamaoka (1973)
Ann Barbara Ho Yee (1972)
Calvin C. J. Sia, Commissioner
Ruth Oda (Hawaii) (1972)
P. M. Cockett (Kauai) (1973)
J. M. Briley, Jr. (Maui) (1974)

Scientific Program Committee

Herbert S. Uemura, Chairman (1972)
L. Clagett Beck (1973)
Walter Y. M. Chang (1974)
Kenneth Gardner (1973)
Mitsuo Hattori (1972)
Reginald Ho (1972)
Richard K. B. Ho (1971)
Glenn Kokame (1972)
John Krieger (1972)
Edward C. W. Lum (1974)
Wilbur S. Lummis (1972)
Richard T. Mamiya (1972)
Willard Miyahira (1974)
Roger Ogata (1973)
Noboru Oishi (1972)
James A. Orbison (1974)
Buenaventura E. Realica (1974)
Millard Seto (1972)
Walton K. T. Shim (1972)
Arnold Siemsen (1972)
K. S. Tom (1974)
Sorrell Waxman (1972)
Edward Y. Yamada (1972)
Francis K. L. Won (1974)
R. Varian Sloan (Ex-Officio)
Coolidge S. Wakai, Commissioner
Edward A. Ballerini (Hawaii) (1974)
Frank Tabrah (Hawaii) (1973)
R. H. Moser (Maui) (1974)
Peter Kim (Kauai) (1974)

Scientific Research Committee

Buenaventura E. Realica, Chairman
(1974)
Windsor Cutting (1973)
Robert T. S. Jim (1974)
Bal Raj Mehta (1972)
Sorrell H. Waxman (1971)
Winfred Y. Lee, Commissioner
R. P. Henderson (Hawaii) (1972)
M. A. Brennecke (Kauai) (1973)
N. G. Achong (Maui) (1974)

Television-Radio Committee

Theodore K. L. Tseu, Chairman (1971)
Claude V. Caver (1971)
Clifford B. G. Chang (1973)
Walter W. Y. Chang (1973)
Ralph Cloward (1973)
Ellis Devereux (1972)
Robert Flowers (1973)
Doris Jasinski (1974)
Rowlin L. Lichter (1972)
Bal Raj Mehta (1973)
William F. Moore, Jr. (1973)
Yoshio Oda (1974)
Thomas Teruya (1972)
Henry N. Yokoyama (1972)
Walter K. W. Young (1972)
Cesar B. De Jesus, Commissioner
Tokuso Taniguchi (Hawaii) (1972)
Ruth E. Oda (Hawaii) (1972)
W. W. Goodhue (Kauai) (1973)
Milton Howell (Maui) (1972)

Water Safety Committee

Michael M. Okihiro, Chairman (1973)
Elmars M. Bitte (1973)
Roger B. Brault (1971)
Ralph Hale (1973)
Mitsuo Hattori (1973)
Virgil Jobe (1973)
Barry D. Miller (1974)
Forrest J. Pinkerton (1974)
Harold Sexton (1973)
James Stewart (1974)
Francis Terada (1972)
Calvin C. J. Sia, Commissioner
Peter Kim (Kauai) (1972)
Michael J. McDonald (Maui) (1974)
Walter S. Loo (Hawaii) (1974)

Woman's Auxiliary Committee

Edward L. Chesne, Chairman (1973)
Philip M. Corboy (1973)
Victor Hay-Roe (1973)
Harold G. Lawson (1971)
Jerome L. Tucker (1972)
Cesar DeJesus, Commissioner
Shizuto Mizuire (Hawaii) (1972)
E. B. Underwood (Maui) (1974)
Casper F. Rea (Kauai) (1974)

Workmen's Compensation Committee

Albert C. K. Chun-Hoon (1974)
(Co-chairman)
William W. L. Dang (1972)
(Co-chairman)
Francis T. C. Au (1973)
Walter W. Y. Chang (1974)
Edward L. Chesne (1973)
Raymond deHay (1973)
Raymond C. Dusendschon (1971)
Lawrence H. Gordon (1972)
Kiyoshi Inouye (1971)
Calvin C. M. Kam (1972)
Rowlin Lichter (1973)
Wallace W. S. Loui (1974)
Herbert K. N. Luke (1972)
Maurice Nicholson (1972)
Francis T. Oda (1974)
Roger Ogata (1973)
Noboru Oishi (1972)
Herbert G. Pang (1974)
L. Q. Pang (1973)
Richard K. S. Pang (1974)
K. S. Tom (1974)
Theodore T. Tomita (1972)
Garton Walli (1973)
Charles S. Judd, Jr., Commissioner
James A. Mitchel (Hawaii) (1973)

J. Alfred Burden (Maui) (1973)
Robert Hamblin (Maui) (1974)

Ad Hoc Committee to Coordinate AMA Clinical Session in Honolulu

George H. Mills, Chairman
Harry L. Arnold, Jr.
Morton Berk
William E. Iaconetti (Maui)
Homer Izumi
David Wm. Jones (Hawaii)
Yonemichi Miyashiro (Kauai)
Richard D. Moore
F. J. Pinkerton
R. Varian Sloan
K. S. Tom
Theodore T. Tomita
Livingston Wong

Ad Hoc Committee to Develop HMA Position on Drug Abuse

Charles W. Stewart, Jr., Chairman
(Maui)
Donald F. B. Char
Frederick A. Dodge
Casimer Jasinski
James Johnston
Stanley Kobashigawa
Felix Lafferty
Joseph T. Lucas
B. R. Mehta
Barry D. Miller
George Starbuck
Neal E. Winn
Calvin C. J. Sia, Commissioner
DeWitt H. Smith (Hawaii)
Albert C. Johnston (Kauai)
Dorothy N. La Fon (Maui)
Reginald C. Carvalho (Hawaii)
Jose Romero (Maui)

AWARDS

Medical Journalism Awards

PROFESSIONAL DIVISION:

1st Prize: Mrs. Pat Hunter
Special Recognition Award: Mr. Sanford Zalburg

EDUCATIONAL DIVISION:

1st Prize: Mr. Allan Chinen
2nd Prize: Mr. Benson Medina

Sportsmen's Awards

TENNIS:

Yutaka K. Yoshida and Leabert R. Fernandez—
Doubles champions

GOLF:

President's Trophy (low net tie):
Manuel Abundo
Joseph Nishimoto
Robert M. Miyamoto Perpetual Trophy (low net tie):
Manuel Abundo
Joseph Nishimoto
John M. Felix Perpetual Trophy (low gross):
B. A. Richardson
George H. Mills Perpetual Trophy for Pharmaceutical
Representatives:
Roy Shimonishi

PROCEEDINGS OF THE HOUSE OF DELEGATES

116th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the president, Herbert Y. H. Chinn, at 1:00 P.M., May 9, 1972, in the Bora Bora Room of the Ilikai Hotel.

Present were (officers) Herbert Y. H. Chinn, William E. Iaconetti, John J. Lowrey, R. Varian Sloan, and Thomas P. Frissell; (county presidents) DeWitt H. Smith, Winfred Lee, K. A. Chuang, and Denis Fu; (councillors) Grover H. Batten, William W. L. Dang, H. William Goebert, Jr., and Peter Kim; (past presidents) Toru Nishigaya, O. D. Pinkerton, and Samuel Yee; (Maui delegate) A. Y. Wong; (Kauai delegate) Yonemichi Miyashiro; (Honolulu delegates) Max G. Botticelli, Clifford B. G. Chang, Charles T. H. Ching, William G. Davis, Frederick A. Dodge, George M. Ewing, Bernard W. D. Fong, Gordon Liu, Robert Nordyke, Calvin C. J. Sia, Philip H. F. Watt, and Walter H. K. Watt.

Dr. J. Mark B. Sowers was seated as delegate for Edward B. Underwood from Maui. Delegates from Hawaii County were seated as follows: T. David Woo for Haruto Okada and Tadao Nagashima for Egbert Fell. Honolulu County alternate delegates were seated as follows: Meryl Haber for Anna M. Brault, William P. Jones for Alfred D. Morris, Masaru Koike for Benjamin C. K. Tom, and Theodore K. L. Tseu for Frederick B. Warshauer.

Dr. Richard E. Ando was appointed parliamentarian. Dr. Theodore Tseu was appointed sergeant-at-arms.

The minutes of the 115th Annual Meeting were approved as published.

The reports of the President, Secretary, and Treasurer as well as those of the component societies were in the Delegates' Handbook and were referred as indicated. The reports of the standing and special committees were referred to the Reference Committees as previously announced. Resolutions 7 and 9 were referred to the Reference Committee on Public Health; Resolutions 8 and 11 to Reference Committee on Insurance and Medical Services; Resolution 6 to Miscellaneous Business; and the reports of the Site Committee, Mabel Smyth Board, and Ad Hoc Committee on the Payne Study as well as Resolution 12 to the Reference Committee on Parliamentary Affairs.

Reference Committees were appointed as follows: Public Health—Calvin Sia, Robert Nordyke, Walter Watt, and Timothy Woo; Insurance and Medical Services—William Dang, Denis Fu, Masaru Koike, Yonemichi Miyashiro, and Theodore Tseu; Miscellaneous Business—Max Botticelli, Clifford Chang, Charles Ching, K. A. Chuang, and George Ewing; Parliamentary Affairs—Bernard Fong, Grover Batten, Peter Kim, O. D. Pinkerton, DeWitt Smith, Mark Sowers, and Samuel L. Yee.

It was voted to reconvene the House of Delegates on May 11, 1972, at 1:00 P.M.

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The Reference Committees were in session May 9, 1972, beginning at 1:30 P.M.

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The second session of the House of Delegates was called to order on Thursday, May 11, 1972, at 1:00 P.M. The secretary called the roll.

Honolulu delegates William Davis and Masaru Koike were absent the second day. Dr. Kenneth Chinn was seated to replace H. William Goebert. Drs. Edward Chesne and H. H. Chun were seated as Honolulu delegates. Dr. Reuben Casile was seated as a delegate from Hawaii County to replace James Mitchell; Dr. Nagashima was absent the second day.

Dr. Wesley W. Hall, President of the American Medical Association, was introduced and asked to address the House.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 20 physicians. It received testimony on the reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AUTOMOTIVE SAFETY

The Automotive Safety Committee had one meeting during the year and presented testimony for House Bill #1774 regarding the restriction of drivers under the influence of narcotics. One of the newspapers has been contacted regarding publicity against the drinking driver and they would like to wait for a specific case to play up. The major concern in highway safety seems to be the problem drinker or chronic alcoholic, much more so than the social drinker, and the Committee feels that uncontrolled alcoholism should be a reportable disease. This, perhaps, requires further exploration before a definite stand is made.

RECOMMENDATION: The Automotive Safety interest should continue but, at least for the present, should be combined with other aspects of public safety.

TRUETT V. BENNETT, M.D.

Automotive Safety

Your Reference Committee first considered the report of the Automotive Safety Committee. No one appeared to discuss this report. Your Committee recommends approval of this report and its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER

The Cancer Committee engaged in the following activities during the past year:

(1) Recommended to the Council the expansion of the Cancer Commission to include two representatives from the University of Hawaii to be appointed by the President of the University. (2) Recommended that the Blood Bank of Hawaii purchase a Blood Cell Separator to service the State with blood components for transfusions. It was felt that such a Separator is needed to allow aggressive therapy for patients with cancer, leukemia and other diseases with decreased blood cell components. The members of the Committee offered to meet with and assist the Blood Bank in this regard. (3) Met with Dr. Palmer Saunders and Dr. Walters of the National Cancer Institute and Dr. Richard Lee and Dr. Fred Greenwood of the Research Corporation of the University of Hawaii regarding the proposed Cancer Research Center of Hawaii. The Committee stated its interest in the Center and would like to play an active role and supply available manpower and talent. A subcommittee was formed to explore the mechanisms available whereby HMA can contribute to this Center. (4) The Committee continued good working relationships with other organizations such as the Cancer Commission, the American Cancer Society and the Research Corporation of the University of Hawaii but did not maintain official liaison with RMP and Tripler Army Hospital as in the past as representatives were not appointed.

The Cancer Commission report will be submitted separately.

There is no budgetary request.

RECOMMENDATIONS:

- (1) The expansion of the Cancer Commission to include two members from the University of Hawaii to be appointed by the President of the University
- (2) That the Cancer Committee recommend and assist in the selection of a Blood Cell Separator, to be purchased and housed by the Blood Bank of Hawaii, to allow aggressive therapy of neoplastic and other diseases requiring blood cell components
- (3) That HMA participate actively in the proposed Cancer Research Center of Hawaii and furnish available manpower and talent
- (4) Continue close liaison with the Cancer Commission, American Cancer Society and other organizations and re-establish liaison with Tripler Army Hospital and RMP.

The Chairman would like to take this opportunity to officially thank the members of the Committee and the secretaries for their interest and assistance.

THOMAS K. L. LAU, M.D.

Cancer

Your Reference Committee then considered the report of the Cancer Committee. Your Committee recommends that the first recommendation be amended to read, "The expansion of the Cancer Commission to include two members who hold membership in the HMA to be nominated by the President of the University of Hawaii from the faculty of the Medical School, thus indicating the cooperative participation of the University." We also recommend that Recommendation No. 2 be amended to read, "That the Cancer Committee recommend the selection of a Blood Cell Separator . . ." deleting the word "assist." Your Committee further recommends that Recommendation No. 3 be accepted, but that portion, ". . . and furnish available manpower and talent" be deleted. We also recommend approval of the last recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMISSION

The Hawaii Tumor Registry reports significant progress during 1971-72 in bringing the Registry up-to-date. A visiting registrar, supported by American Cancer Society funds, and the registry personnel in many larger hospitals have completed the abstracting of *all* cancer cases through 1969. Many hospitals are complete through 1971 at present. In the Central Registry itself, a large volume of cases have been coded and this back-log reduced to reasonable proportions. The Registry has made application to the proposed Demographic Program of the Cancer Research Center at the University of Hawaii for funds for computerization and additional personnel. It is the Commission's hope that, with computerization, significant reports on cancer experience will be available to all hospitals in Hawaii within the next year.

The Registry is preparing to assist several important cancer research programs, with significant statistical information and plans, to develop suitable procedures for applications for statistical and research assistance from the Registry.

DRAKE W. WILL, M.D.

Cancer Commission

Your Reference Committee then considered the report of the Cancer Commission and accepts this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CHRONIC ILLNESS AND AGING

The Committee on Chronic Illness and Aging met several times during the past year. The Committee agreed that a major problem facing the chronically ill and the aged is lack of adequate housing. There is a severe lack of intermediate care homes where patients could be placed who do not require the skilled nursing care that is required in extensive care facilities. A meeting was held with several agencies, including DSS, Oahu Health Council, Hospital Association of Hawaii, and the State Health Department to discuss this problem. Letters were sent to members of the Legislature, urging their consideration of funds to provide for intermediate facilities.

The Committee encouraged physicians to become acquainted with the health facilities and resources available to them in meeting different needs of health care, for example, Medicaid, nursing homes, Blind Rehabilitation Center, etc.

The Committee also agreed with the suggestion that the committees on Diabetes, Heart, Cancer, and Mental Health become subcommittees under the Committee on Chronic Illness and Aging.

RECOMMENDATION: The Committee recommends that a primary role for the coming year would be to pursue the program of providing more intermediate care facilities.

ARTHUR K. WONG, M.D.

Chronic Illness and Aging

Your Reference Committee next reviewed the report of the Chronic Illness and Aging Committee, and had discussion which was very strong that HMA participate actively in the recommendation that a primary role for the coming year would be to pursue the program of providing more intermediate care facilities. In addition, your Committee feels that review of the legal building requirements be reviewed. HMA recognizes that this requires total community effort in achieving this.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC HEALTH

The Commission on Public Health consists of the following Committees: Automotive Safety, Cancer, Chronic Illness and Aging, Communicable Disease & Immunization, Venereal Disease & Tuberculosis, Crippled Children, Diabetes, Environmental Health, Heart, Maternal & Perinatal Mortality Study, Mental Health, Radiation, School Health, Water Safety and Ad Hoc Committee on Drug Abuse. I endorse the reports of each Committee.

I would highly recommend the immediate establishment of the Chronic Disease Committee to consist of the Chairmen from Aging, Diabetes and Heart Committees, and defer inclusion of Cancer and Mental Health from this consortium at the present time. Since the Cancer Committee is HMA's direct liaison with current developments in research and services in the community, this should remain a separate Committee at this time. The suggestion of the Mental Health Committee Chairman to place a member in various committees should be attempted. The Committee's function could be reevaluated in another year.

The suggestion of a Public Safety Committee combining the function of Auto Safety, Water Safety, and Radiation is well accepted. This should be established as soon as feasible.

The Ad Hoc Committee on Drug Abuse should become an active Committee. I recommend that this become a standing Committee called Substance Abuse Committee.

Since liaison has been established with the Departments of Health and Education, as well as the community, the School Health, Crippled Children, and Maternal & Perinatal Mortality Study Committees should be maintained. A reevaluation of each Committee's function could be made in another year.

Environmental Health and Communicable Disease should be maintained as separate standing Committees at this time.

I wish to commend the efforts of the Chairmen of the following Committees who maintained active meetings with their respective Committees throughout the past year: Cancer, Diabetes, Drug Abuse, Chronic Disease, Communicable Disease, Environmental Health, Maternal and Perinatal Mortality Study, School Health, and Water Safety.

RECOMMENDATIONS:

- (1) Establishment of Chronic Disease Committee utilizing the Chairmen from Aging, Diabetes, and Heart as the nucleus with subcommittees formed as necessary in each of these three areas within the Committee
- (2) Establishment of Public Safety Committee, combining the function of Automotive Safety, Water Safety, and Radiation. The present Chairmen of these Committees should be included
- (3) Establishment of a standing committee for Substance Abuse.

CALVIN C. J. SIA, M.D.

Commission on Public Health

Your Reference Committee then discussed the report of the Commission on Public Health. Your Committee recommends that recommendation one be amended to include Mental Health as a subcommittee under the Chronic Disease Committee. Your Committee also recommends the addition of recommendation four to read, "Keep Crippled Children and School Health as separate standing committees in the Public Health Commission." Your Committee also recommends the addition of recommendation five to read, "Move Maternal and Perinatal Mortality Study Committee to Medical Education Commission."

ACTION:

The President ruled that the recommendation of the Reference Committee regarding committee structure was out of order since action on that subject had been taken during the report of the Committee on Parliamentary Affairs.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

COMMUNICABLE DISEASE

The Communicable Disease Committee was involved in two main issues during the past year: Smallpox immunizations, and a program to combat venereal disease.

The Committee discussed whether or not it was necessary to continue the practice of smallpox immunizations. This was prompted by the recommendation to discontinue the practice of routine smallpox immunizations by the U. S. Public Health Service, American Academy of Pediatrics, and the Hawaii Chapter of the A.A.P. and the Honolulu Pediatric Society.

The Committee also participated with the Department of Health and the Department of Education in formulating a Comprehensive Program to Combat Venereal Disease as mandated by House Resolution 319. This report was presented to the Legislature on February 1, 1972.

RECOMMENDATIONS:

- (1) That the Hawaii Medical Association defer making specific recommendations on smallpox immunizations at the present time

- (2) That the HMA and its members actively participate in the Comprehensive Program to Combat Venereal Disease, especially in the area of specific physician involvement.

(Reprinted below from report to the Legislature)

L. T. CHUN, M.D.

HMA PARTICIPATION IN THE COMPREHENSIVE PROGRAM TO COMBAT VENEREAL DISEASE

1. The problem of incomplete reporting must be analyzed and through a process of self-education and self-regulation, the Hawaii Medical Association and other professional groups must take steps to increase reporting. Some form of encouragement should be arranged to obtain compliance by non-reporters.
2. The Hawaii Medical Association should take steps to educate its members on the need for screening high risk asymptomatic women. Each patient receiving pelvic examination for whatever reason should be cultured. From nationwide results, they can expect at least a 2% yield.
3. The Hawaii Medical Association should take the responsibility to see that its members are made aware of the need for reculturing and occasionally retreatment. Since the Health Department can supply medications when needed and will perform laboratory services for reculture, this will not add undue cost to the patient. If the physicians are unable or unwilling to perform these necessary steps, then, the patients should be referred to the State clinic for reculture.
4. The Hawaii Medical Association should make arrangements to serve as a source for speakers and consultants on venereal disease community education programs and to take the responsibility to educate their own patients when appropriate on venereal disease.
5. The Hawaii Medical Association should continue to make use of its resources including its Speaker's Bureau of physicians interested in the venereal disease problem to frequently inform the public about venereal disease ("Medically Speaking," etc.). It should continually encourage patients who are sexually active to seek medical examination after they have had an exposure that appears to be suspect.
6. In their role as leaders in our community, physicians also enjoy the opportunity to involve themselves in encouraging young people through peer leadership groups to take up the banner of venereal disease control as they have pollution, war and other major social "ills." Here lies a great untapped wealth of personnel who can make the solution of our venereal disease problem much easier by making the large majority of our target group aware of their responsibility in this matter.

Communicable Disease

Your Reference Committee then considered the report of the Communicable Disease Committee, and accepts this report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CRIPPLED CHILDREN

The Committee held one meeting during the past year and another meeting is scheduled for April 8, 1972.

At the previous meeting, various services offered by the Crippled Children Branch of the State Department of Health were reviewed. The question of budget, to serve all the handicapping conditions was discussed. However, due to a lack of funds all categories of handicaps are

not included in the Crippled Children Branch of the Department of Health. However, some of the voluntary agencies are serving other handicaps and efforts were made not to duplicate these services.

Dr. Connor from the DOH sent a breakdown of their budget to the various categories which was distributed to all the Committee members. The Crippled Children Branch budget will be discussed at the next Committee meeting.

One of the recommendations of the Committee on Commissions was that the Crippled Children Committee be transferred to Medical Services Commission. It is the opinion of the Chairman of this Committee, as well as some of the other members, that the Committee should remain as such within the Public Health Commission. The objectives of this Committee are to function as a liaison between the Crippled Children Branch of DOH, various agencies providing services for handicapped children and the HMA, and see that such services are being provided and make appropriate recommendations. Therefore, this Committee would fit more appropriately within the Public Health Commission. This subject, as well as the budget of the Crippled Children Branch of DOH, will be discussed at the next Crippled Children Committee meeting April 18, 1972.

D. V. REDDY, M.D.

CRIPPLED CHILDREN COMMITTEE— Supplemental report

Since the annual report was submitted, the committee met April 18, 1972, and the various aspects of the reorganization of the committee was discussed. It was the opinion of all the members present that the Crippled Children Committee should include broader aspects for the services of the handicapped children and look into the comprehensive services for these children rather than the fee aspect.

RECOMMENDATION: The committee recommends that the Crippled Children Committee should remain as a committee functioning within the Public Health Commission. However, if it is felt by the Committee on Commissions that there are too many committees at the present, then it will be more appropriate to include the various services for children under one committee such as Children and Youth, School Health Services, Crippled Children, and name it "Child Health Committee" to function under the Public Health Commission. The proposal was seconded and unanimously accepted by the committee members.

D. V. REDDY, M.D.

Crippled Children

Your Reference Committee then discussed the report and supplemental report of the Crippled Children Committee. Your Committee recommends that this committee be maintained as a standing committee under Public Health Commission for another year. Your Committee also recommends that the Children and Youth Committee be deleted.

ACTION:

The President ruled that the recommendation of the Reference Committee regarding committee structure was out of order since action on that subject had been taken during the report of the Committee on Parliamentary Affairs.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

DIABETES

The Diabetes Committee completed the standardization of diabetes detection, which included: (1) methodology of glucose analysis, (2) interpretation of data with establishment of normal values for plasma, serum, and whole blood, (3) reporting of data. The final forms

have been sent to the various county diabetes committees for their evaluation and approval.

Plans were completed with the Lions Club and the State Department of Health for a Detection-Screening Clinic to operate on Saturdays (bi-monthly). The Nurse-Technician will be subsidized by the Lions Club, the laboratory tests will be performed by the State Department of Health, and the HMA and County Diabetes Committees will act in an advisory capacity.

The Committee analyzed the data of the detection drives performed by the various county societies. The drives served a dual purpose of public service and education.

The Fourth Annual Camp for Diabetic Children was held under the supervision of HMA and the Hawaii Dietetic Association. Again, the Lay Diabetic Society subsidized the program amounting to \$400, and were responsible for the registration of the children with the YMCA.

The Committee also considered the concept of a Chronic Disease Committee, composed of subcommittees of Diabetes, Heart, Cancer, and Crippled Children.

RECOMMENDATIONS:

- (1) That the Diabetes Committee be a subcommittee of a Chronic Disease Committee
- (2) That HMA urge all County Societies to adopt the standardized method of Diabetes Detection
- (3) That the Committee continue to investigate newer methods of diabetes detection
- (4) That HMA officially endorse the Lay Diabetic Society, Inc., and recommend that they continue to work under the HMA advisory staff.

WILLARD MIYAHIRA, M.D.

Diabetes

Your Reference Committee then considered the report of the Diabetes Committee. Your Committee recommends that the first recommendation be accepted. We also recommend that the second recommendation be amended to read, "... adopt the standardized method and criteria of Diabetes Detection." We recommend the third and fourth recommendations be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DRUG ABUSE, AD HOC

During the past year, our Committee has devoted most of its energies to advancing the recommendations it sponsored last year in the form of the report of the Hawaii Committee on Drug Abuse. Although the Commission, that we suggested, was not formed, the chief societies saw fit to organize a Governor's Ad Hoc Committee on Substance Abuse which assumed many of the projected duties of the proposed Commission. Our Association has been represented on this body by the Chairman of this Committee and by another member from time to time. At first it seemed as though the Governor's Committee was getting little support, but quite recently it has received assurances that it will have some resources to carry out its program. Therefore, it is the feeling of our Committee that major emphasis be placed on continuing very active participation in the Governor's group, and supporting the same objectives that we did last year.

Above and beyond our contributions to this state organization on Substance Abuse, we feel that we must carefully review, as a body, various inputs and stances that reflect purely medical opinion. We intend to remain quite active in passing on to the President, Commissioners, and Council our views on a wide variety of substance-related topics. In turn, we need feedback on the opinions of the Association which need presentation to the Governor's Committee.

Broad educational and other concerns have received less attention this year while we await trends and movement at higher levels.

CHARLES STEWART, M.D.

Ad Hoc Committee on Drug Abuse

Your Reference Committee then considered the report of the Ad Hoc Committee on Drug Abuse, and accepts this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ENVIRONMENTAL HEALTH

The Environmental Health Committee met weekly during the fall months and biweekly during the spring. During the fall we became acquainted with a broad perspective of the State's environmental problems by having guest speakers from the State Legislature, governmental officials, and leaders of active environmental groups. The spring found the Committee reacting primarily to the various bills and resolutions of the Legislative session. Also, throughout the year, members of our Committee made field visits, attended outside meetings and hearings, and delivered testimonies on environmental matters.

We have found that Hawaii has statutes on its books which allow the enforcement of many anti-pollution efforts, but because of concomitant economic and political considerations, the environment and our "quality of life" more often than not, take a back seat. We feel this Committee serves the very important function of being a strong advocate for the betterment of the physical and mental health of John Q. Public through advocating a healthier environment with a priority on our "quality of life."

RECOMMENDATIONS: That HMA, through its Environmental Health Committee:

- (1) Continue to support strong, meaningful legislation on matters of environmental health
- (2) Strongly advocate the proper enforcement of rules and regulations governing environmental pollutions
- (3) Initiate anti-pollution and pro-health efforts in areas where current legislation is inadequate, as in the health aspects of pesticide misuse
- (4) That HMA underwrite the expenses involved in sending a Committee Representative to the Annual AMA Congress of Environmental Health and Council on Environmental and Public Health in 1973.

BUDGET REQUEST:

Travel funds and per diem	\$360.00
Registration fee	40.00
TOTAL	\$400.00

LEIGH SAKAMAKI, M.D.

Environmental Health

Your Reference Committee then considered the report of the Environmental Health Committee. Your Committee recommends that the report and recommendations be accepted. The budget request has been included in the report of the Treasurer. Your Committee commends the committee chairman, Dr. Leigh Sakamaki, for his efforts.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ACTION:

It was voted to reconsider the report of the Environmental Health Committee. A motion was made and seconded to amend Recommendation No. 4 of the report by adding the following phrase at the end of the sentence: "... if economically feasible as determined by the President." The motion passed. The report was adopted as amended.

HEART

The Heart Committee held no meetings this year. Since this Committee has been virtually inactive for the past few years, it is recommended that it be incorporated with the proposed Chronic Disease Committee.

COOLIDGE S. WAKAI, M.D.

Heart

Your Reference Committee next considered the report of the Heart Committee and accepts this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MATERNAL & PERINATAL MORTALITY STUDY

The Committee met three times during the year and investigated a total of six maternal deaths. Four occurred in 1971 and two in 1972. Discussions of the cases, and subsequent classifications were performed at these meetings. The Committee was unable to investigate perinatal deaths due to the inability of obtaining the death certificates through the State Department of Health. This perinatal death certificate review has recently been reinstituted and such case studies should be resumed in the near future. Information is also being gathered for a retrospective review of perinatal deaths.

The major work of this Committee continues to be provided by approximately twelve members who attend relatively regularly. The advisability of revising the format of this Committee and its method of presentation should be considered. Possibly, a smaller committee composed of obstetricians and pediatricians should select cases to be presented at two open meetings a year, i.e. open to all physicians in the state. One of these meetings could be confined to maternal deaths, and the other to perinatal deaths during the past year. This may provide the educational outlet for the Committee which is presently unsatisfactory. Consideration should also be given to publishing selected old (beyond the statute of limitations) cases in the HAWAII MEDICAL JOURNAL as is done in the NEW ENGLAND JOURNAL OF MEDICINE.

RECOMMENDATIONS:

- (1) That a change in the method of case presentation be considered to enlarge the educational value of the Committee's work
- (2) That consideration be given to publishing old, but instructive, cases in the HAWAII MEDICAL JOURNAL.

BUDGET REQUEST:

Telephone calls to neighbor islands
for case reviews \$50.00

ANN B. CATTS, M.D.

Maternal and Perinatal Mortality Study

Your Reference Committee then discussed the report of the Maternal and Perinatal Mortality Study Committee. Your Committee recommends that this report and its recommendations be accepted, with the addition of a third recommendation which reads, "That the Maternal and

Perinatal Mortality Study Committee be moved to the Medical Education Commission and the Peer Review Commission. The budget request has been included in the report of the Treasurer.

MENTAL HEALTH

During the past year no items were referred to this Committee by Council, or from other committees. Three items were considered serious enough to be pursued spontaneously: improvement in insurance coverage of psychiatric treatment; a Bill introduced in the Legislature that would have markedly altered admission procedures to psychiatric facilities; and the matter of peer review in private practice.

One Committee meeting was held jointly with a committee of the Mental Health Association and Mr. Albert Yuen of HMSA, to review improvements in coverage of out-patient treatment and psychological testing about to be implemented. Further sessions with Kaiser and others on the same general topic, and possibly getting into discussion of National Health Insurance had been anticipated, but proved hard to schedule.

One meeting was held with Dr. Roat of the Mental Health Division and with representatives of the Mental Health Association at the Community Service Center on the Bill to change admission procedures, resulting in presentation of testimony before the House Health Committee by the Chairman.

Finally, the Chairman had discussions with several persons concerning peer review of private psychiatric care for out-patients, resulting in a suggestion to Dr. Max Botticelli, of EMCRO, that a panel of psychiatrists in private practice and out-patient clinics be formed to work with EMCRO in trying to develop some system of peer review which could be applied to evaluation of care given to non-hospitalized patients.

The Committee on Commissions has proposed that this Committee be placed with a number of others in a Committee on Chronic Disease. It is the opinion of the Chairman that this would be most inappropriate, as the great majority of mental conditions treated are not chronic, the field of psychiatry concerns itself with the subject matter of all the other suggested committees, especially drug abuse, public safety, state of the environment, and children and adolescents as well as adults. A counter-proposal was made that to each of the other committees, a liaison person from the Mental Health Committee be assigned. This would keep the Committee abreast of matters coming to other sectors of HMA which have mental health implications, and might spread to other committees the orientation toward prevention that now characterizes psychiatry.

RECOMMENDATIONS:

- (1) That this Committee continue meeting on appropriate topics with the Mental Health Association and/or other relevant community groups
- (2) That the Committee work with EMCRO on developing a peer review method for office practice of psychiatry
- (3) That members of this Committee be assigned as liaison with all other HMA committees concerned with topics or fields of medicine in which there may be a mental health aspect
- (4) That the Committee again next year develop one or more workshops, seminars, or courses relating to aspects of mental health and/or social and family relationships
- (5) That HMA send one delegate from this Committee to the AMA Annual Meeting of State Mental Health Representatives.

BUDGET REQUEST:

Travel expenses to AMA Meeting \$600.00

GEORGE F. SCHNACK, M.D.

Mental Health

Your Reference Committee then discussed the report of the Mental Health Committee. Your Committee recommends that recommendations one and two be accepted, and that recommendation three be amended to read, "That members of this subcommittee under Chronic Illness and Aging be assigned as liaison with all other HMA committees concerned with topics or fields of medicine in which there may be a mental health aspect." Your Committee accepts the last two recommendations, and recommends that a sixth recommendation be added, "That the Mental Health Committee be placed under the Chronic Diseases Committee as a subcommittee." The budget request has been included in the report of the Treasurer.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. A motion was passed to amend Recommendation No. 5 by adding a phrase at the end of the sentence as follows: "... if economically feasible as determined by the President." The amendment passed.

It was moved and seconded to adopt this portion of the report as amended. It was adopted.

RADIATION

The Radiation Committee did not meet during the year.

CARL W. BOYER, JR., M.D.

Radiation

Your Reference Committee then considered the report of the Radiation Committee, and accepts this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCHOOL HEALTH

Three members from the HMA School Health Committee attended the AMA School Health Committee meeting held in Chicago, where a report of the Hawaii School Health Service Pilot Program was made.

The Department of Education survey on drug abuse was discussed and questions were directed to the Department of Education representatives who made the survey. The results of the survey will give direction to the education of students on drug abuse. A follow-up survey will be made in the near future to see the effect of the education on drug abuse.

The Committee continued its support for the School Health Service Pilot Program by informing legislatures of the result of the first year experience in the pilot program. It is the ultimate goal to have the services extended to all public schools in Hawaii.

A possible change in the Department of Education school regulation whereby medication may be given in school was discussed with the Superintendent of Department of Education and he has initiated steps necessary to see if this is possible.

ROY KUBOYAMA, M.D.

School Health

Your Reference Committee then discussed the report of the School Health Committee, and accepts the report. Your Committee recommends that his committee remain as a standing committee. Your Committee commends Dr. Roy Kuboyama for his chairmanship.

ACTION:

The President ruled that the recommendation of the Reference Committee regarding commit-

tee structure was out of order since action on this subject had been taken during the report of the Committee on Parliamentary Affairs.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

WATER SAFETY

The Water Safety Committee had three meetings during the year. Mr. Bill Edwards, President of the Hawaii Diving Council, gave us a report on SCUBA diving accidents and informed us of the investigations that he had been doing through the Mayor's Committee on Water Safety.

At our second meeting, Mr. Al Minn, Chairman of the Mayor's Committee on Water Safety, gave us an overall view of their activities. The Mayor's Committee is very active in all aspects of water safety and invited us to send a representative to their monthly meetings. However, our Committee members felt they could contribute little at the present time, but agreed to attend should the need arise.

During the past year, Mr. Benton Chun of the University of Hawaii did a study on drowning incidents on Oahu during the past decade. His study was performed with the help of Dr. Ralph Hale and myself. A full report will be forthcoming in the near future.

At our last meeting, we agreed with the suggestion of the Committee on Committees to merge the duties of this Committee with the Public Safety Committee.

MICHAEL M. OKIHIRO, M.D.

Water Safety

Your Reference Committee then considered the report of the Water Safety Committee, and recommends that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 1 AS ADOPTED

Re: American Cancer Society

WHEREAS, the American Cancer Society, Hawaii Division, has continued to show its deep interest in the Hawaii Cancer Commission of the Hawaii Medical Association by its substantial yearly financial support of the Hawaii Tumor Registry, now therefore be it

Resolved, that the Hawaii Medical Association express its deep appreciation to the American Cancer Society and its Board of Directors for their generosity and interest.

Submitted by DRAKE W. WILL, M.D.

Resolution No. 1

Your Reference Committee then considered Resolution No. 1, and accepts this resolution.

ACTION:

The Chairman recommended that Resolution No. 1 be adopted. It was adopted.

RESOLUTION NO. 2 AS ADOPTED

Re: Cancer Programs

WHEREAS, the Bureau of Research and Planning was given the task by the President and the Council of the HMA of clarifying the relationship of the Cancer Committee, the Cancer Commission and the Hawaii Tumor Registry to the role of the Hawaii Medical Association in the matter of the evaluation and control of cancer in the State of Hawaii, and

WHEREAS, the Bureau conducted this study in depth over several meetings and heard a wealth of testimony

from persons intimately connected with cancer research, and

WHEREAS, the Bureau presented its findings to the Council on 25 February 1972, after which the Council heard additional testimony from the University of Hawaii Research Corporation and then acted to adopt the following, now therefore be it

Resolved, that this House of Delegates confirm the action of the Council, to wit:

(1) That the Hawaii Medical Association reaffirm its original conception of the Hawaii Cancer Commission and the Hawaii Tumor Registry as being functions of the HMA with cooperative participation of the Department of Health and the American Cancer Society, Hawaii Division;

(2) That the Hawaii Cancer Commission be enlarged by the addition of two members to a total of eight;

(3) That the President, University of Hawaii, be invited to nominate from the faculty of the Medical School two, who hold membership in the HMA, to these positions, thus indicating the cooperative participation of the University.

And be it further Resolved, that appropriate wording be incorporated into the Bylaws of the Association to reflect the inclusion and proper position and functions of the Hawaii Cancer Commission and its Tumor Registry within the structure of the Hawaii Medical Association.

Submitted by J. I. FREDERICK REPPUN, M.D.

Resolution No. 2

Your Reference Committee then considered Resolution No. 2, and accepts this resolution.

ACTION:

A motion was made and seconded to correct the first "resolved" to read "American Cancer Society, Hawaii Division." The amendment was passed.

The Chairman recommended that Resolution No. 2 as amended be adopted. It was adopted.

RESOLUTION NO. 7 AS ADOPTED

Re: Family Planning

WHEREAS, contraceptive procedures, supplies, and information are not readily available as a practical matter to many persons in this State, and

WHEREAS, it is desirable that inhibitions and restrictions be eliminated so that all persons desiring contraceptive procedures, supplies and information shall have ready and practical access thereto, and

WHEREAS, Federal statutes now in force require all persons on Aid for Dependent Children programs regardless of age, marital status, etc. be provided with family planning information and services, and

WHEREAS, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice and the House of Delegates of the American Medical Association recommend that doctors prescribe contraception for sexually active minors on their own consent, now therefore be it

Resolved, that the Hawaii Medical Association adopt the following position statement:

• The unmarried minor of any age whose sexual behavior exposes her to possible conception should have access to the most effective methods of contraception.

• In order to accomplish this, the individual physician, whether working alone, in a group or in a clinic, should be free to exercise his best judgment in prescribing contraception and, therefore, the legal barriers which restrict his freedom should be removed.

• These restricting legal barriers should be removed even in the case of an unemancipated minor who refuses to involve her parents. A pregnancy should not be the price she has to pay for contraception. On the other hand, in counseling the patient, all possible efforts should be made to involve her parents.

- The contraceptive services should be offered whenever possible in a broad spectrum counseling context which would include mental health and venereal disease.
- Every effort should be made to include male partners in such services and counseling.

GEORGE GOTO, M.D.

Resolution No. 7

Your Reference Committee then considered Resolution No. 7. Your Committee recommends that the position statement of the American College of Obstetricians and Gynecologists be amended to read, "The unmarried minor whose sexual behavior exposes her to possible conception . . ."

ACTION:

A motion was made and seconded to amend Resolution No. 7 by resolving that this resolution shall be the position statement of the HMA rather than "of the American College of Obstetricians and Gynecologists."

The Chairman recommended that Resolution No. 7 be adopted as amended. It was adopted.

RESOLUTION NO. 9 AS ADOPTED

Re: Community Health Education

WHEREAS, the President's Committee on Health Education said in a preliminary report that the government—particularly the HEW Department—has failed to provide leadership and resources for consumer health education, and

WHEREAS, this same Committee has also stated that there is evidence that the next major advance in the health of our citizens will come through health education and preventive medicine and not necessarily through more doctors and high-cost hospitals, and

WHEREAS, all citizens should know what constitutes good health, how to achieve it, or how to maintain the most optimum level of health possible, and

WHEREAS, community health education is a major component of preventive medicine in all socio-economic levels of life, and

WHEREAS, there is a need for relatively uniform and informed approach to the problem, now therefore be it

Resolved, that the 1972 House of Delegates of the Hawaii Medical Association urge the American Medical Association to develop guidelines and gather materials for state associations to use in the implementation of community health education, these resources to cover both general health and specific illnesses, for use by public health nurses, rural areas, private and governmental physicians, schools, and any other group interested in broadening community health education.

RICHARD S. OMURA, M.D.

Resolution No. 9

Your Reference Committee then considered Resolution No. 9, and accepts this resolution.

ACTION:

A motion was made and seconded to amend Resolution No. 9 by deleting those words following the last comma. The amendment was passed.

The Chairman recommended that Resolution No. 9 be adopted as amended. It was adopted.

ACTION:

The Chairman move adoption of this report as a whole. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee on Parliamentary Affairs met to discuss the various items of business presented to it by the House of Delegates. The hearings were attended by approximately 25 members of the HMA, and there was an indepth discussion of all the reports presented before the committee. The committee is pleased to make the following report:

AMA STUDY OF HMA, AD HOC

This report was transmitted to President Herbert Chinn with a covering letter as follows: "The attached report is a third draft of your ad hoc committee's report. The committee has not critically reviewed the report and I do anticipate comments and recommendations for modification. Time prevented me from having it ready in the completed form for the House of Delegates meeting. Sincerely /s/ George H. Mills, M.D., Chairman, Ad Hoc Committee on AMA Study of HMA."

At the request of the Council of the Hawaii Medical Association a Survey Team from the American Medical Association conducted a study of the "entire presence" of the HMA.

The AMA Survey Team included—

1. James H. Sammons, M.D., Board of Trustees, AMA
2. Mr. W. Harold Parham, Executive Vice President, Florida Medical Association
3. Mr. Richard Layton, Director, Field Service Dept., AMA
4. Mr. David Weihaupt, Assistant Director, Field Service Dept., AMA

Their work was conducted from August 8 thru August 13, 1971.

The completed report was presented to the Council of the HMA in October 1971. At this Council meeting it was unanimously agreed that the five living past presidents of the Hawaii Medical Association were to comprise an ad hoc committee to review the report of the AMA team and present their findings to the HMA Council and House of Delegates at their spring meeting. The committee included Drs. Mills, Pinkerton, Lowrey, Tomita, Richardson, and Dr. Allison was also asked for his opinion.

Each section of the study was reviewed by a subcommittee comprised of members who had special expertise on the subject matter.

Well over three hundred hours were contributed by committee members to review the issues and submit their reports.

In the following report we have attempted to summarize some of the pertinent points gleaned from a review of the AMA Survey Team report.

We recommend that this report—the report of the AMA Survey Team—and the reports of the subcommittees be made available to all delegates to the HMA. At a later date, convenient to the majority of its members a special HMA House of Delegates meeting be held to review, discuss, and implement portions of the reports that will improve the status of organized medicine in Hawaii.

The Ad Hoc Committee begs leave to present this review of the AMA Survey Team Study of the HMA as follows:

Part I—Hawaii Medical Association—Internal

A. AMALGAMATION OF THE HAWAII MEDICAL ASSOCIATION AND THE COUNTY MEDICAL SOCIETIES

Dr. John Lowrey

It was the opinion of your ad hoc committee that the basic intent in the amalgamation of HMA and the county societies was to develop a unit that would allow the joining together of the administrative staffs of the

HMA and all county societies, and a sharing of their responsibilities.

Your ad hoc committee agreed unanimously that the present county medical societies should continue as discrete entities. At present, amalgamation would involve only administrative sharing. The degree of administrative sharing depends upon current studies of goals and objectives for the HMA and County Societies. These studies should include the reassessment of the functions of all HMA and county committees with special attention being given to combining the functions of various committees and transferring all committees to the HMA when feasible.

B. PHYSICAL PLANT (HEADQUARTERS OFFICE)

Dr. O. D. Pinkerton

There was unanimous agreement by your ad hoc committee that the present physical plant housing HMA and HCMS is inadequate. The present cramped quarters limits the scope of work and efficiency of the staff. Any positive program of amalgamation must include (HMA-HCMS-BME-HFMC-counties) at least 6,000 sq. ft. of work space. This space is not available at the Mabel Smyth building at present. Several alternatives were reviewed.

- (1) Alteration of present Mabel Smyth Building. Cost: \$175,000-\$200,000.
- (2) Renting 6,000 sq. ft. Cost: \$3,600 per month.
- (3) Purchase of a building—6,500-7,500 sq. ft. Cost: \$400,000.
- (4) Erect own building—\$400,00 plus land, \$250,000. Cost: \$600,000 to \$1,000,000.

If we are to effectively and adequately serve the membership of HMA, the county societies and the citizens of the State of Hawaii, 6,000 square feet of office space is necessary. A realistic target date to acquire this space, 1974.

C. CHARTER AND BYLAWS OF HMA

Dr. Harry L. Arnold, Jr.

In spite of the anticipated changing responsibilities (amalgamation) and new demands on the HMA—its officers—executive director—staff—commissions—etc., the constitution and bylaws must be critically reviewed and modified so as to keep this Association—viable—productive—and in the mainstream of the health care system of this country.

Your ad hoc committee reviewed a few areas for suggested change.

1. The HMA Council modified to—
 - (a) limit the term of office of a council member—(?—10 years).
 - (b) add presidents of four county medical societies as voting members of the council.
 - (c) add three additional councillors from HCMS. (On February 1972 active membership of HMA 838, Oahu 697, Hawaii 59, Maui 49, and Kauai 33.)
 - (d) each county society will be responsible for transportation and per diem for all of its members on the council.
 - (e) council meetings increased to one every month (presently, 4-5 times a year).
 - (f) at least two council meetings held on neighbor isle per year.
 - (g) Council members nominated and elected by their respective county medical societies.
 - (h) the chairman of the council be the HMA president-elect.
2. Commissions of the Association be adequate in order to minimize or eliminate present inefficient, costly and cumbersome committee system.
 - (a) increase ad hoc committee use by each commission.
 - (b) each county society nominate and elect their own representatives to a committee or commission.

- (c) the president of the HMA may ask for a committee or commission substitute if already seated individual expires, is frequently absent, etc.
- (d) representatives from labor, management, lawyers, government-deprived-insurance, etc. could be added to a commission or committee.
- (e) members of commission reappointed annually with a limit of 10 years.
- (f) suitable liaison be developed with specialty societies. Adequate representation of specialty societies in HMA system developed.
- (g) suitable liaison with the degree granting medical school be developed.
- (h) a major effort must be generated to establish and maintain good press relations and community relations.

D. EXECUTIVE DIRECTOR

Dr. Claude Caver

Your ad hoc committee reviewed areas D, E, F, G of this report with Dr. Caver. We agreed unanimously that if the amalgamation of HMA and county societies is to be pursued, a clear definition (management agreement) of the responsibilities—duties—authority—etc., of this office must be developed and clearly defined. There should be one office, one staff, one boss with the necessary authority to run the show. The director must be allowed to utilize modern and sensible methods of consultation and consensus but having sole responsibility for results.

Although there is confusion in this area at present, the Peat, Marwick and Mitchell Report of 1970 would be a good place to start.

E. ASSISTANT EXECUTIVE DIRECTOR

Again your ad hoc committee agreed unanimously with the report of Dr. Caver. We agree with the Survey Team's recommendation, page (2) (a) thru (f). These sections spell out clearly the responsibilities of the Assistant Executive Director to the Director and the county societies.

F. STAFF

The staff of the HMA should be adequate—well balanced—clearly and efficiently directed—equitably reimbursed, and of the highest quality so as to truly represent the highest level of professionalism found in medicine.

During this period of transition as we move to amalgamation there is no reason to believe we will be free of some uncertainty—anxiety—confusion in direction among all members of the staff.

If the work of reorganizing the staff is to be carried out efficiently and in a business-like fashion the Executive Director must be given a full and free hand. He can be encouraged to seek help when feasible from his assistants—staff—officers and county society representatives, etc.

Staff organization should start immediately, utilizing previous studies and all other resources.

G. EQUIPMENT AND MATERIAL

All necessary equipment shall be well used—well repaired—readily accessible. Equipment should be bought—rented—leased when feasible to best serve all demands including those new demands precipitated through amalgamation. The HMA must establish a realistic equipment budget. This budget shall take into account those money responsibilities that are correctly the obligation of each county society.

H. FINANCES

Dr. Thomas Frissell

Your ad hoc committee agrees with Dr. Frissell and his committee that any realistic prediction of future income and expenditures cannot be drafted until we know more definitely the scope of the amalgamation.

The major source of income is dues. Other sources are nebulous. Redesigning the committees and future devel-

opment of commissions could decrease cost. However, as greater demands are made on your society so will the cost increase.

At present then, no prediction with reasonable fiscal integrity can be made regarding the effect of the amalgamation.

I. PUBLICATIONS

Dr. Harry L. Arnold, Jr.

In reviewing this section of the Survey Team report it was again pointed out the difficulties encountered in communicating positively and effectively with our membership. The recommendations of a monthly Bulletin, Legislative Bulletin, Leadership Bulletin, etc. should be accepted and studied.

J. PROGRAMS

Dr. Elisabeth Anderson

"... there are few well planned ongoing programs for the benefit of the membership." Your ad hoc committee accepts for further study the recommendation of Dr. Anderson's committee that:

1. An annual society officers conference be held to orient the societies to current problems and activities of the HMA. To exchange ideas regarding these issues.
2. A compulsory orientation conference for all new members of all county societies.
3. Support programs designed for office personnel to improve office personnel and patient relations.

Part II—Hawaii Medical Association—External

A. BUREAU OF MEDICAL ECONOMICS

Dr. Winfred Lee

It was the impression of the ad hoc committee that housing the BME under the same roof with HMA, HCMS, etc. could precipitate significant economies. It is the present opinion of the BME officers and staff that branches of the BME cannot function on a sound financial basis if established on the neighbor islands.

Since this has been a continual request of neighbor island county medical societies the issue should be explored in depth and official opinion drafted.

The Control Data Corporation service should be explored in an attempt to better serve the Bureau and the physicians.

B. FOUNDATION FOR MEDICAL CARE

Jon Won

The BME and Foundation can exist under the same roof. They may share staff and equipment but further consolidation is impossible due to clear differences in purpose.

In order to anticipate local and national programs (PSRO), and provide quality service to the citizens of Hawaii, the Foundation is moving rapidly and positively to a position of control by the HMA.

C. LIBRARY

Dr. Grover Batten

Your ad hoc committee recommends that the relationship of the HMA to the library remains unchanged.

D. LEGISLATURE

Dr. George Goto

Dr. Goto's report to your ad hoc committee was discussed and accepted. Listed are major points with which his committee agrees or disagrees.

1. Agree that lobbying and legislative issues are a continual year around activity, and that present lobbying arrangements be reviewed.
2. Disagrees that legislative counsel be eliminated.
3. Agree that HMA leadership should participate in hearings and lobbying activities (significant contributions may be made prior to actual public hearings).

4. Agree that the Executive Director and his assistants should lobby if they have the expertise—the time—and can cultivate the necessary trust with the legislators.
5. Agree that the "Key Contact System" of Kentucky be explored.
6. Agree a legislative bulletin during the session would be helpful.

E. MEMBERSHIP—NEIGHBOR ISLANDS

Dr. B. Allen Richardson

Dr. Richardson and Mr. Thorson visited each of the neighbor island county societies. The following issues were discussed and the neighbor island physicians volunteered the following:

1. All county presidents should be a voting member of the HMA Council.
2. County representatives on the council should be elected by the county societies.
3. Counties should have more voice in the selection of their representatives to HMA commission and committees.
4. Counties do want to maintain the present system of county societies.
5. There should be established a clear-cut definition of division of responsibilities between county societies and HMA.
6. The HMA Council should meet more frequently and once on each major neighbor island each year.
7. Regular visits of the Executive staff should be scheduled with neighbor island county societies.
8. The president of HMA and County Societies should be allowed to be in office for two consecutive years.

Your ad hoc committees reviewed these issues and found them to be reasonable. It is recommended they be reviewed and discussed in detail in anticipation of possibly implementing those that are acceptable.

F. MEMBERSHIP—GENERAL

This area was reviewed. It was pointed out that the HMA did negotiate for the stabilized rate structure for malpractice insurance.

Several county societies and the HMA have already developed programs encouraging non-members to join. As an adjunct to this endeavor it was suggested that non-members be invited to HMA functions as guests.

Also, a more concentrated effort should be made to involve medical students, interns, and residents in local functions sponsored by organized medicine.

The inter-relationship of doctors of osteopathy and doctors of medicine in Hawaii should be studied.

G. HMA—RELATIONSHIP WITH OTHER HEALTH ORGANIZATIONS

Dr. Wilbur Lummis

1. *Medical School*
The Hawaii Medical Association has taken a positive stand in support of a four-year medical school. Recent meetings sponsored by HMA involving representatives of the health care industry contributed greatly to the positive decision by the State legislature in developing a degree granting school. It is important that HMA and the University of Hawaii School of Medicine continue close liaison as this new school develops.
2. The liaison with the Hawaii Hospital Association has improved considerably over the past few years. The liaison and understanding must continue to expand so that we may avoid the trap of being pitted against each other by bureaucrats who would choose either of us or both to be the whipping boys of the health care cost dilemma. The involvement of the State of Hawaii, through Act 97, in the hospital business makes it very important especially for neighbor island doctors that we communicate well with the Hawaii Hospital Association.

3. Liaison with the Hawaii Medical Service Association is fair. Except for a few nationally oriented health insurance programs, HMSA enjoys almost a monopolistic control of the health and accident insurance coverage in Hawaii.

Slowly but surely government and the health insurance industry are realizing true peer review (not fiscal review) must be done by actively practicing medical doctors.

It is most important for these reasons that better communications with HMSA be established.

4. *CHP & RMP*

Communications between the HMA and these two government-sponsored agencies are well established. A definite partnership atmosphere has developed over the past few years. This is manifested at present in the EMCRO project and recent work on a statewide emergency care system.

5. *Major Medical Groups—HMO*

The relationship between the large organized group practices and HMA has changed very little. A much clearer understanding of the principles and practices of the Kaiser group by HMA and vice-versa has alleviated severe pre-existing tensions. Even now, however, poorly informed citizens, doctors, legislators, etc. will occasionally try to rupture the amicable lines of communication between the Kaiser Foundation Health Plan and HMA.

Regarding HMOs, your ad hoc committee continues to support the view of AMA. A pluralistic health care delivery system is good for Hawaii. HMOs are an experiment in health care delivery. There are enough of the HMO experiments already starting up (110). Before we commit the HMA, let us evaluate these 110 experiments.

Part III—Hawaii Medical Association Community Relations

*Drs. T. Tseu, G. Goto, P. Walsh, M. Hasegawa,
and F. Soon*

It is apparent from the reports in this section that much more planning, time, effort and dollars must be spent to set our house in order.

The problems that confront HMA as spelled out by the reports of these sub-committees are identical to problems faced by organized medicine nationally.

It is strongly recommended by your ad hoc committee that in the process of committee and commission reorganization, special effort and emphasis be placed on developing a vehicle that will be sensitive to medicine's problems when interfacing with the community.

Also, a mechanism be developed to deal immediately and realistically with the issues.

In conclusion, a special thanks to all ad hoc committee and subcommittee members for their input in this report.

Ad Hoc Committee Members

JOHN J. LOWREY, M.D.

O. D. PINKERTON, M.D.

B. ALLEN RICHARDSON, M.D.

THEODORE T. TOMITA, M.D.

GEORGE H. MILLS, M.D., CHAIRMAN

AMA Study of HMA, Ad Hoc

Your Reference Committee first considered the report of the Ad Hoc Committee on AMA Study of HMA. Your Committee recommends that this preliminary report be accepted in principle and upon completion of the final draft that it be submitted to the HMA Council for study and approval and subsequent transmission to the membership at the discretion of the Council. The Committee would like to commend the Ad Hoc Committee for its diligence and hard work and recommends that their work be continued until the completion of the Constitu-

tional Convention in the fall of 1972. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BUREAU OF RESEARCH AND PLANNING

The Bureau held its first meeting on July 13, 1971; it has had a total of ten meetings with an average attendance of 9.4 members out of 22 listed on its roster.

At its first two meetings it deliberated at some length on what the Bureau's proper purposes and functions should be. Next, it was briefed on the role of Regional Medical Program Hawaii on the future of the practice of medicine. The Bureau also listened to a presentation by two lay students on the concern on the part of consumers (the public) with the delivery of health care in Hawaii. However, the Bureau's major task in 1971-1972 was to determine the role of HMA and its Cancer Committee, Cancer Commission and Tumor Registry in the community. This was at the request of the HMA Officers, with particular reference to the request for input from the Research Corporation, University of Hawaii, and to the new emphasis on Cancer nationally. A total of six meetings were held on this subject. The last meeting was held jointly with the HMA Council at which the Bureau's formal presentation was made on February 25, 1972.

Having initiated several broad new programs for the HMA in past years, such as the HMA—Beverly Payne Study of the Quality of Medical Care in Hawaii, EMCRO, etc., the Bureau has on its agenda for next year the following:

- A: To determine how best to relate consumer concern with physician delivery of quality health care;
- B: To review the relationship of the Hawaii Medical Library to the HMA, its component County Societies, the specialist societies, the University of Hawaii and the community.

J. I. F. REPPUN, M.D.

Bureau of Research and Planning

Your Reference Committee next considered the report of the Bureau of Research and Planning and noted with interest the ongoing projects as submitted by its chairman. We recommend approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BYLAWS AND PARLIAMENTARY

The Bylaws and Parliamentary Committee has been observing the activities of the various committees and sub-committees that have been studying the report of the AMA study group that visited the HMA in the summer of 1971.

It is apparent that the major thrust of the report as far as the HMA organizational structure is concerned has to do with the pattern of committees.

The Bylaws Committee agrees with the principle that the committee structure spelled out in the Bylaws as at present is too rigid and complex and does not lend itself to the flexible approach that is essential in the rapidly changing scene of today. In addition, there are far too many committees with limited application and functions that are so restricted that they have practically no impact on the activities of HMA.

The Committee appreciates and understands the recommendations of the Committee on Commissions. It does support the resolution extending the authority of the Council in reorganizing the committees pending final definition in the Bylaws. It believes that the best service

would be rendered by repealing the entire section of the Bylaws relating to commissions and committees and substituting therefor the authority of ad hoc appointments.

The Committee supports the idea of a later convening of the House of Delegates to consider the full revision of the Bylaws. This should be done only after some experience is gained through the use of the Committee plan as recommended by the Committee on commissions.

In regard to the proposed special meeting of the House of Delegates we would like to submit the attached material for discussion and for information only. The suggestions contained therein are only suggestions and are intended to be thought-provoking, preliminary to final discussion and decision.

Chapter III, Section 3—second sentence: The President-elect may be elected for a period up to two years, after which he shall serve as President for two years and as Past President for two years.

Chapter III, Section 1—second sentence: There shall be 10 Councillors, 4 of them the current Presidents of their respective county medical societies, *ex officio* but with voting privileges, who, together with. . . .

Chapter V, Section 1e—The Council shall consist of 10 councillors. . . .

Chapter V, Section 1f—Each County shall have at least one councillor in addition to its current President, who shall serve during his term as a Councillor *ex officio*, with vote.

Chapter VIII—To be repealed in its entirety, temporarily, and in its place to read:

Commissions and committees shall be appointed ad hoc by the President with the advice and consent of the Council, pending a more efficient arrangement and organization of these structures.

HARRY L. ARNOLD, JR., M.D.

Bylaws and Parliamentary

Your Reference Committee next examined the report of the Bylaws Committee and discussed the articles of change suggested by that Committee. Your Committee recommends that this report be referred to the Constitutional Convention for study and final action and in addition the Committee suggests that the Council not be limited to ten members but should be flexible and related to the membership in each county. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON LEGISLATION

The Commission on Legislation consists of the Legislative, National Legislation, Pharmacy and the Professional Liability Committees. The reports of the committees are self explanatory and will not be repeated in this report.

If plans to re-organize the commission and committee structure of the Association are finalized, the Pharmacy and the National Legislation Committees will be incorporated within the Legislative Committee and the Professional Liability Committee will be transferred to the Commission on Peer Review and Medical Services. These actions will leave the Commission on Legislation with but one Committee, the Legislative. Since all legislative proposals of the Association are channelled through the Legislative Committee, this Committee could become the most active of all committees. Its members consist in part of all chairmen of other commissions and committees having legislative proposals.

It is vitally important that the leadership in the Association continue to increase its participation in legislative hearings and other lobbying activities. It is encouraging to note that over the past several years more and more physicians have become involved in the legislative

process and have learned through trial and error that bills do not necessarily pass on their merits alone, and that our legislators are responsive to our efforts to improve the quality of medical care by enacting meritorious medical bills.

GEORGE GOTO, M.D.

Commission on Legislation

Your Reference Committee next considered the report of the Commission on Legislation and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMITTEE ON COMMISSIONS, AD HOC (As Adopted)

The Committee on Commissions was formed to consider the reorganization of the Committee and commission structure. Each commissioner presented his views relative to his respective commission. Listed below are the committees and commissions which became effective as of the Council Meeting on April 14, 1972, on an experimental basis.

I. MEDICAL EDUCATION AND PEER REVIEW COMMISSION

- A. *Medical Education Committee*—This was felt to be necessary and was an active, functioning Committee. The AMA-ERF Committee had been changed last year to the Scientific Research Committee but had not been active. It was felt that the function of this Committee—to collect research data and data on research projects—could be assumed by the Medical Education Committee.
- B. *Peer Review Committee*—This Committee should become one of the more important and active committees. It will encompass the functions—to be established—of the peer review structure as determined for the State as well as the functions of other committees relating to peer review, ie, Adjudication and Medical Care Plans Committees. Thus, the Adjudication and Medical Care Plans Committees are to be eliminated.
- C. *Professional Liability Committee*—As this Committee, in its function of providing the HMA with a sound malpractice insurance program, is involved with peer review, it has been moved to this commission from the Legislation Commission.
- D. *Publications*—Necessary in producing HAWAII MEDICAL JOURNAL and in setting editorial policies, determining fiscal policies, and advertising standards.
- E. *Maternal & Perinatal Mortality Study*—It was felt that this Committee is in the realm of education and should be moved to this commission from the Public Health Commission.

II. INTERNAL AFFAIRS COMMISSION

- A. *Convention Committee*—The Arrangements Committee and the Scientific Program Committee dealt exclusively with the HMA Annual Meeting. As it is necessary to coordinate the efforts of both, it was felt wise to combine these two committees. As the Convention Committee, concerned with conventions and meetings involving the HMA, this Committee would also assume the functions of the Ad Hoc Committee on the AMA Clinical Meeting in Hawaii, realizing that it can call on people that have the contacts regarding this Clinical Session.
- B. *Bylaws and Parliamentary Committee*—No question as to its necessity and will become a most active Committee.

C. *Woman's Auxiliary Committee*—This Committee should be retained as a liaison with the Auxiliary although it was felt that this Committee should combine the functions of both the HCMS and HMA auxiliary committees.

III. LEGISLATION COMMISSION

A. *Legislative Committee*—This is by far the only active Committee in this Commission. National Legislation Committee is a frustrating experience and much of its activities, if any, can occur only after such legislation is a matter of record. The activities of the National Legislation Committee can be assumed by the Legislative Committee and HMA officers. Also, the functions of the Pharmacy Committee are mainly in the area of legislation and such functions can be assumed by the Legislative Committee. Thus, National Legislation and Pharmacy Committees are to be eliminated.

IV. MEDICAL SERVICES COMMISSION

A. *Fee Survey Committee*—As this Committee has a definite, on-going function of producing the RVS, it must be retained. Also, since one function of the Underprivileged Medical Committee relates to fees for DSS clients, this function is to be assumed by this Fee Survey Committee. The other function of the Underprivileged Medical Care Committee, relating to health services for underprivileged communities, will be transferred to the Community Health Care Committee. Thus, the Underprivileged Medical Care Committee is to be eliminated.

B. *Workmen's Compensation Committee*—This Committee should be retained as is.

V. PUBLIC HEALTH COMMISSION

A. *Children and Youth Committee* be created to replace School Health Committee. Also includes Crippled Children Committee.

B. *Chronic Illness and Aging Committee*—This Committee should be kept but its functions expanded into all chronic illnesses. This Committee will have the following as subcommittees: (1) Aging, (2) Diabetes, (3) Heart, and (4) Mental Health. Thus, the Diabetes, Heart, and Mental Health Committees will not be standing committees in this Commission.

C. *Communicable Disease Committee*—This Committee is active in immunization programs as established by the Department of Health and is necessary.

D. *Environmental Health Committee*—An active Committee and should be kept as a separate Committee.

E. *Substance Abuse Committee*—Formerly an Ad Hoc Committee on Drug Abuse, it was felt that it should be changed in name to reflect its concerns with all abused substances and should become a standing committee.

F. *Public Safety Committee*—This Committee is a new one that will assume the functions of the Auto Safety, Water Safety, and Radiation Committees.

G. *Cancer Committee*—This Committee remains as a standing committee.

VI. INTERPROFESSIONAL AND PUBLIC AFFAIRS COMMISSION—(Renamed from Interprofessional and Public Relations Commission)

A. *Public Affairs Committee*—A new Committee which will assume the functions of the Public Relations, News Media, Quackery and Operation Pacific Committees that now exist in this Commission as well as the functions of the Awards & Special Projects Committee as shifted to this Commission from the Internal Affairs Commission.

B. *Health Facilities Committee*—The Hospital Committee, which had been recommended be eliminated last year, had survived with the hope of

COMMISSIONS
(As Adopted)

MEDICAL EDUCATION & PEER REVIEW	INTERNAL AFFAIRS	LEGISLATION	MEDICAL SERVICES	PUBLIC HEALTH	INTER- PROFESSIONAL & PUBLIC AFFAIRS	HEALTH SERVICE AND CARE
Medical Education	Convention	Legislative	Fee Survey	Chronic Illness & Aging	Public Affairs	Community Health Care
Peer Review	Bylaws & Parliamentary		Workmen's Compensation	Communicable Disease	Interprofessional Relations	Emergency Services
Professional Liability	Woman's Auxiliary			Cancer	Intraprofessional Liaison	
Publications					TV-Radio	Health Manpower
Maternal & Perinatal Mortality Study				Children & Youth	Health Facilities	
				Environmental Health		
				Substance Abuse		
				Public Safety		

becoming active. Just recently, the Hospital Committee had become active in negotiating an agreement between the Medical School and community hospitals. However, it was felt that the Hospital Committee had its function originally relating to hospital education. This function would be assumed by the Medical Education Committee. The name would become Health Facilities Committee and would be concerned with maintaining liaison with all health facilities, in problems relating to HMA.

- C. *Interprofessional Committee*—A new Committee which will assume the functions of the Association of Professions, Careers, and Medicine & Religion Committees now existing in this Commission.
 - D. *Intraprofessional Liaison Committee* be created whose functions would be to have liaison with the specialty societies, house officers, and medical students.
 - E. *TV-Radio Committee*—To retain its functions of producing "HMA Hotline" as well as assuming the functions of the Japanese Speakers Bureau and the Filipino Speakers Bureau, as subcommittees.
- VII. HEALTH SERVICES & CARE COMMISSION—This is a newly created commission because there is so much occurring in the area of health services delivery.
- A. *Community Health Care Committee*—A most active Committee that is presently a joint Committee for the HCMS and HMA.
 - B. *Emergency Services Committee* will be created to handle all matters relating to emergency medical care (including Disaster).
 - C. *Health Manpower Committee*—A very active Committee that should be retained to handle the functions relating to medical and allied health manpower.

COMMITTEE AND ORGANIZATIONS RESPONSIBLE TO THE COUNCIL: In addition to the Bureau of Research and Planning, and the Finance Committee, the Cancer Commission (with its Tumor Registry), Community Research Bureau, and EMCRO and Quality of Care Study be directly responsible to the Council.

RECOMMENDATIONS:

- (1) That the House of Delegates reaffirm the Council's decision to implement this report of the Committee on Commissions and establish committees on an ad hoc basis
- (2) That these new ad hoc commissions and committees develop goal and functions within three months after their formation which will be reviewed by the Committee of Commissions and presented to the Council
- (3) That following an appropriate trial period with these ad hoc commissions and committees, that a special House of Delegates meeting be called for the appropriate constitutional changes.

WINFRED Y. LEE, M.D.

Committee on Commissions, Ad Hoc

Your Reference Committee next considered the excellent report of the Ad Hoc Committee on Commissions. Your Committee recommends the following changes and corrections to the report:

- Section I (E): Correct the word "Maternity" to read "Maternal." In the same paragraph, substitute the word "education" for "peer review."
- Section II (C): Correct title is "Woman's Auxiliary Committee."
- Section IV (B): It is recommended that the Crippled Children Committee be removed from the Medical Services Commission and merged with the Children

and Youth Committee under the Public Health Commission.

Section V (A): Add Crippled Children to this committee.

Section V (B): Correct name of committee to read Chronic Illness and Aging Committee. It is recommended that Cancer be removed as a subcommittee of Chronic Illness & Aging Committee and that a separate Cancer Committee be formed (Will become Section V (G) under the Public Health Commission).

Section VII (B): Add parenthesis at the end of the last sentence to read (including Disaster).

Committee and Organizations Responsible to the Council: Delete the words "the Nominating Committee" and place the Nominating Committee under another section entitled Committees and Organizations Responsible to the House of Delegates.

The organization chart should reflect the appropriate changes noted above. Your Committee recommends approval of all recommendations and acceptance of the report as amended.

ACTION:

A motion was made to delete the parenthesis, (Including Disaster) from Section VII(b). The motion was defeated.

It was moved that the Cancer Committee be made a subcommittee of the Chronic Illness and Aging Committee under the Public Health Commission. The motion was lost.

The Chairman moved adoption of this portion of the report. It was adopted.

EXECUTIVE DIRECTOR

A great deal of energy has been expended during the past year on the problem of determining the direction we will take when the reorganization of HMA is completed. The American Medical Association review team that came to Hawaii, to study the situation following our staff merging, opened a real Pandora's box of problems.

It would appear that restructuring of our committees is one of the most pressing needs. The present committee structure does not seem to be suited to current needs for flexibility and definitive action. In conjunction with this, more specific general policy statements are needed for committee guidance and direction.

With the need for providing service to nearly eighty committees, the staff is burdened with what appears at times to be busy work rather than functional action. Planning for committee work is weak in many instances and agendas are poorly prepared. The result has been a high resistance from neighbor island societies to attend committee meetings.

A fairly large number of physicians are serving on various planning groups that are working on health care programs in the state. Not all of these physicians are appointed by HMA, and consequently do not necessarily represent the Association. In the eye of the public, however, they do represent the medical profession and are presumed to reflect the views of all of the doctors. It is important that clear policy be established by HMA, and that doctors serving in the capacity of Board members be acquainted with such policies. It is most desirable that these men be appointed by and responsible back to HMA with adequate feedback so that HMA can be aware of the various activities affecting the profession.

A number of dynamic changes are taking place in Hawaii. EMCRO, under our own wing, is well into its second year. HMOs have made their advent on Maui with a pilot program. Altogether, six different agencies have become involved in health care planning with very little communication between them. All, by the way, federally funded.

The staff is spread fairly thin. I am proud of them and their ability to handle heavy work loads with a minimum of fuss. It would be helpful if the total personnel of

HCMS and its subsidiary the BME, and HMA could be housed together, in order to make maximum efficient use of common functions.

Funding our activities is a continuing problem and frequently is a puzzle. The Finance Committee should be given direction by the Council to develop a budget that is in balance. The House of Delegates should not modify the budget, but return it to the Council if not acceptable. We must maintain some degree of fiscal responsibility and a continual procession of deficit budgets puts a severe strain on the Treasurer.

Political activity can now be stepped up. No longer is it necessary that we maintain HAMPAC in an isolated position from HMA. The new law regulating political activity makes it possible for us to provide staff support to HAMPAC without getting into trouble. The reporting of activities is complex, under the new regulations, and it will require additional staff time to carry out the functions of HAMPAC.

Contacts with the neighbor island societies will be increased. There will be planned visits by staff to the county societies for the purpose of keeping them informed and to obtain feedback information from them. It is hoped that all county societies will have some form of staff support in the near future. It is planned that we will give limited help, particularly in training and support for such staff.

Relationships with SAMA are good. We have established a line of communication and our rapport is in excellent shape.

As this is written, it is unknown whether the legislature will approve the development of a degree-granting school of medicine. On the assumption that they will do so, HMA and particularly President Chinn, can claim a real share of the credit for the working out of the relationships with the community hospitals and the school. Dr. Chinn took on the onerous job of acting as intermediary to resolve some of the problems and succeeded remarkably well.

As the degree-granting medical school emerges, it is anticipated that the philosophical changes that are taking place will inject the school more and more into the field of the delivery of health care services. The thrust of federal legislation will almost force this upon us and it well behooves us to be in the picture from the very beginning so that your services will be delivered in accordance with your wishes as far as possible. Expect to be called upon to give serious thought to the pattern of practice that will unfold as the government becomes more and more involved in the medical care field.

Politically, we do not expect a national health insurance bill to pass Congress in 1972. We will get some form of HMO and PSRO legislation but in a form that we can live with. It is probable that there may be a coalition of Wilbur Mills and Senator Kennedy. If this occurs there will be an all-out battle for a health insurance bill. Congress is not inclined to give everybody everything at the moment. It would appear that the medicredit idea of the AMA will have a major impact on any legislation now being considered.

Locally, in our state legislature, we have watched with interest and have testified on a number of legislative proposals. Because of deadlines for the printers, I cannot report on what has happened. We have been active in the field of legislation concerning malpractice insurance, consent of minors, physician's assistants, emergency medical services, the medical school, community health planning, etc.

The rate of change is accelerating. The demand upon the profession for ideas and for imagination in the development of innovative methods of delivery of health care is growing by leaps and bounds. The future of medicine can be pretty well determined by medicine itself through its participation in the overall planning. Only a united front and forceful and positive action can maintain the freedom that American Medicine has enjoyed.

H. TOM THORSON

Executive Director

Your Reference Committee next considered the report of the Executive Director and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FINANCE

The Finance Committee has met almost monthly to review the financial status of the Association and to determine how well we were following the assigned budget.

A considerable amount of time was spent considering possible new sources of income for Association needs. No reliable new sources were found. We probably need a minimum of \$100,000 for investment purposes in order to obtain worthwhile income-producing property.

The disposition of the Benevolent Fund is still to be solved despite much thought to determine what should be done with it.

It is estimated that the Association will break even on the cost of producing the 1971 Roster.

THOMAS P. FRISSELL, M.D.

Finance

Your Reference Committee next considered the report of the Finance Committee and recommends that some mechanism be devised at the Constitutional Convention by which the Finance Committee's activities can be made more adaptable to investment procedures. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HMA-PAYNE STUDY, AD HOC

This ad hoc committee, established by the HMA Council at its April 14, 1972, meeting, met on April 29, 1972. Present were Drs. F. Reppun, W. Lee, H. Chinn (ex-officio), and Mr. J. Won. The action of the HMA Council did not reflect the areas in which recommendation should be made. This committee agreed that there are three areas of the Study that should be considered:

1. Continuation—should the Study be continued or dropped;
2. Publication—should the Study be published;
3. Evaluation—does this Study give a true impression of the quality of care in Hawaii.

Area 1. This committee agreed that although this Study is finished, EMCRO is already a fact and is a continuation of the HMA-Payne Study, and the committee agreed that there is a need for this continuation by which criteria is used to evaluate medical care.

RECOMMENDATION: This committee recommends that the HMA-Payne Study be continued through EMCRO to assure continuing evaluation and education to provide optimum medical care for all of Hawaii's people.

Area 2. The question of publication really revolves around what should be released from this point on as there has already been publication of this Study.

RECOMMENDATION: This committee recommends, for the purpose of publicizing this Study, two steps:

1. Meet with all hospital administrators, with an invitation to all County Medical Society presidents to attend, to inform them as to what HMA is planning in the way of publicizing this Study, and to receive input from these people as to what information should be released;
2. Release information simultaneously to UPI and AP

and be prepared, if desired by the press, for follow-up press conferences.

Area 3. From an evaluation of this Study, a number of conclusions were drawn:

1. By measurement of the process of medical care (documentation), it would appear that physicians in Hawaii did not do well.
2. In those diseases where outcomes are determinable, it would appear that the physicians in Hawaii did well.
3. The measurement of the process of medical care (documentation) has no statistically significant correlation with the outcome of medical care delivery in this Study.
4. Modal physicians (specialists who care for patients with a diagnosis in that specialty) in Hawaii measure the process of medical care (documentation) better than non-modal physicians.
5. We have yet to develop a complete measure of the quality of medical care. Although the process of medical care (documentation) is an important part of the evaluation of the quality of medical care, there still remain other important aspects in the measurement of the quality of medical care, such as outcome, patient satisfaction, physician satisfaction, management, and cost of care, that are yardsticks by which the quality of medical care must be evaluated.

Although we are well along in evaluating medical care, the final method by which the quality of care can be evaluated is still in the formative stage.

6. The Physician Performance Index (PPI) could be better worded as the Physician Documentation Index (PDI).

RECOMMENDATION: With the results of this excellent Study, EMCRO should be able to develop a complete method of evaluating the quality of medical care.

WILLIAM IACONETTI, M.D.

HMA-Payne Study, Ad Hoc

Your Reference Committee next considered the report of the Ad Hoc Committee to Evaluate the HMA-Payne Study. Under Area 2, Recommendation 1, we recommend that the "Study" be correctly identified as "Episode of Illness" and "Office Care Study." In Area 3, Conclusion 1, it is suggested the phrase "due to the involved physicians setting ideal quality standards" be added to the end of that sentence. We also recommend that the entire Recommendation under Area 3 be deleted and the following substituted: "Considering the results of this excellent HMA-Payne Study, EMCRO should be able to develop a more complete method of evaluating the quality of medical care." Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections.

It was moved and seconded to amend the report as follows: "That the Ad Hoc Committee to Evaluate the HMA/Payne Study be abolished." This amendment was defeated.

It was moved and seconded to amend the report as follows: "That the Ad Hoc Committee to Evaluate the HMA/Payne Study be continued." This amendment was passed.

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII COUNTY

We are holding monthly meetings (occasionally two a month) with, for the most part, scientific programs. Meet-

ings outside Hilo were held during 1971, in Waimea and Kona. A policy we should continue. Attendance represents about a quarter of the members. As many live at a distance, this seems fair.

On January 10, 1971 there was an active membership of 54. There have been three losses (two deaths and one transfer) and nine gains. As of December 31, 1971, membership was at 60.

Plans involve attempting to attract members to meetings by good programs and other means. We have had a fortunate series of enlightening visiting speakers. Cooperation of the Queen's program and other Oahu-based units in diverting visiting authorities to Hilo has helped, and is certainly appreciated.

DEWITT H. SMITH, M.D.

Hawaii County

Your Reference Committee next considered the report from Hawaii County and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII EXPERIMENTAL MEDICAL CARE REVIEW ORGANIZATION (EMCRO)

1. *Goal*—The goal of this project is to establish an ongoing system of quality of medical care review in the State of Hawaii.
2. *Objectives*—A. To provide consultation and technical staff assistance for continuous institutional-based medical care review. B. To develop the procedural and technical methodology for effective review of the quality of ambulatory care in a variety of settings. C. To provide a continuing system of interval feedback on quality of ambulatory and institutional-based patient care.
3. *Background Information*—A. Identification of Needs and Resources. In 1965, the Hawaii Medical Association established the Bureau of Research and Planning to examine the health needs of the State of Hawaii. After consideration of many aspects of medical care delivery, this committee in 1967 proposed to the HMA Council that a preliminary survey of the quality of medical care in the State be conducted in order to determine the advisability of a comprehensive survey of the quality of health care. This preliminary survey was conducted in 1967 by Dr. Paul J. Sanazaro, a consultant from the Association of American Medical Colleges. The Survey report was published in the July, 1968 issue of HAWAII MEDICAL JOURNAL. As a result of the survey's recommendations in August, 1969, the Bureau of Research and Planning invited Dr. Beverly C. Payne of the University of Michigan to develop and conduct a comprehensive study of personal medical care in Hawaii. In 1970, three phases of the study designed by Dr. Payne were initiated through funding from the National Center for Health Services Research and Development. These phases included: an episode of illness study, an ambulatory care study, and a continuing education phase.
It is from this background of activities in peer review, that in 1971, HMA applied for Experimental Medical Care Review Organization funding from the National Center for Health Services Research and Development. In June 1971, Hawaii's EMCRO was one of only eight EMCRO's funded nationally. A two-year research grant was awarded.
- B. Regional Cooperative Arrangements. The first experimental year of the project was June 30, 1971 to May 31, 1972. Significant progress was made during this time. Below is a summary of accom-

plishments during the first experimental year: 1. A functioning organization and institutional relationships were developed. 2. First round recruitment resulted in 6 hospital and 215 physician members. 3. Criteria, abstract forms, and printout formats were developed for 14 ambulatory diagnoses and 16 hospital diagnoses. 4. Departmental performance goals were set at each hospital. 5. Contracts have been signed with the Commission on Professional and Hospital Activities for processing hospital data. 6. The data processing system for ambulatory care was developed and pretested using the Want mini-computer. 7. Medical record abstractors were trained. 8. Four feedback seminars were held on Oahu, four held on the neighbor islands. 9. The project acted as a community resource by responding to special requests for quality assessment.

Proposed accomplishments of the second experimental year, June 1, 1972 to May 31, 1972, are summarized below: 1. Recruit 6 additional hospital and 200 additional physician members. 2. Complete cycle of review, feedback and review of ambulatory care. Emergency care and hospital clinic care will be included. 3. Complete 2 cycles of review, feedback and review for hospital care. 4. Measure changes in performance for ambulatory and hospital care. 5. Plan and develop an extended care facility component of medical care review. 6. Develop mechanism for support of an operational program. 7. Write final report of the experimental phase. Staffing resources and cooperative relationships were developed during the experimental phase.

MAX G. BOTTICELLI, M.D.

EMCRO

Your Reference Committee next considered the report on the activities of EMCRO. We recommend a minor change in the first sentence of the report to read as follows: The goal of this project is to establish an ongoing system of review of the quality of medical care in the State of Hawaii. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ACTION:

The Chairman moved adoption of this report as a whole. It was adopted.

HONOLULU COUNTY

Communication, commitment and change have been the major goals of our society this year. Whether the efforts rendered will result in a constructive outcome and more importantly in a stronger and cohesive medical profession remains to be seen.

Perhaps the most thought-provoking and stimulating report on the status of organized medicine in Hawaii has been the AMA Study of the HMA which is being reported separately by the HMA Blue Ribbon Committee of Past Presidents. This Committee should be commended for their dedication and time in preparing their report. The HCMS also studied the AMA Study in detail and our recommendations were presented to the Blue Ribbon Committee. The AMA Study stated that the HCMS is the most powerful and dominant society in our state and this is a fact. It is, however, my personal opinion that the medical profession needs more powerful and "dominant" societies to cope with the many problems facing organized medicine today. The HCMS attained this "distinction" by serendipity since the obvious fact is that the majority of the physicians reside in this county. Nevertheless, it is clear that the

voice of organized medicine should be the HMA. It is suggested that HMA be strengthened by having each component society become more responsive and knowledgeable, by allowing each county society president to have a vote on the HMA Council and thereby stimulate internal communication, and by urging that the HMA Council meet more frequently so that it can cope with problems more rapidly and effectively.

Communication within our medical society needs improvement and this year the officers, staff and I have initiated a visitation program to the hospitals and larger clinics on this island to gather input from individual members in the hope of becoming a more responsive society. The response has been gratifying and in most instances advantageous to all involved. These visitations indicate that a communication gap truly exists amongst our busy practicing physicians and that the needs of the society cannot always be fulfilled if one does not endeavor to obtain the grass root opinions.

The Board of Governors has just completed a survey of all the committees of the HCMS. The Committee on Commissions report indicates the need to streamline the HMA committee structure which has grown to such an extent that it has resembled an ineffective bureaucracy with more than 50 committees. The HCMS will also undergo an internal reorganization and will amalgamate and eliminate committees. Some of the activities of the HCMS will be transferred to the HMA. These efforts in internal reorganization should aid both organizations.

The major activities of the society on a committee level have been in community health planning and in the areas of peer review activities. The community health planning committee, one of the most active committees of the HCMS will be transferred to the HMA in view of the importance that health care and delivery is attaining statewide. The peer review organizational changes will continue and be implemented to amalgamate all existing peer review type committees. The existing medical practice committee is gaining stature as an objective review board and it must be emphasized that this precedent must be followed in all peer review activities.

The Foundation is continuing its efforts with the self-insured program and exploring this program with several unions and large employers. The Bureau of Medical Economics has operated efficiently and profitably for the society. The need to have the Bureau under one roof with the HCMS is being explored and would be helpful for greater efficiency.

Although the year is only one-third over for our officers, their efforts, the Board of Governors dedication and the hard-working committee chairmen should all be commended. I wish to thank all these members and our staff for their dedication and efforts to strengthen our society.

In closing, I would like to reiterate that rational change can only be achieved by commitment of informed physicians. The challenges are increasing and can only be met by commitment from busy practicing physicians for if this sacrifice is not made, decisions will be made by other well-intentioned but non-medical groups.

RECOMMENDATIONS:

- (1) That the county medical society presidents be made members of the HMA Council with the power to vote.
- (2) That the Committee on Commissions report be implemented and approved after a trial period of evaluation, by the House of Delegates.
- (3) That all county medical societies establish their own peer review activities as soon as practical and that these peer review activities be carried on objectively and judiciously.

WINFRED Y. LEE, M.D.

Honolulu County

Your Reference Committee next considered the report of Honolulu County and recommends the following

changes: That Recommendation 1 be changed to read "That the Bylaws be revised to allow county medical society presidents to . . ."; that Recommendation 2 be changed to read "That the Committee on Commissions report be implemented and after a suitable trial period, be reevaluated by the House of Delegates before final action" and that Recommendation 3 be amended to read "That all county medical societies, who have not already done so, establish their own peer review activities . . ." Your Committee recommends approval of the report as amended.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COUNSEL

Your legislative counsel's primary function for this year was to further legislative action in the area of medical malpractice suits. This involved legislative enactment of a more precise and meaningful statute of limitations for the filing of actions based on medical malpractice.

The necessity for such a measure as stated in Standing Committee Report No. 475-72, Senate Committee on Judiciary, is as follows:

"The law at present does not specifically limit the time within which a suit based on medical malpractice must be brought, other than the general requirement for all actions in tort . . . By judicial construction, the commencement of this two-year period of limitation has been construed to begin after the discovery of the existence of injury. It is conceivable, therefore, that an action in tort for medical malpractice may be filed years after the commission of the act constituting the alleged tort, at a time when evidence tending to prove or disprove the claim may have become unavailable as a result of the lapse of time."

The legislation proposed by the Hawaii Medical Association would have continued the present two-year period of limitations with, however, one important change—there would have been an overall period of limitations of six years from the time of the commission of the act constituting the alleged tort, during which all actions must be brought. This would have had the effect of providing a specific period of six years for filing of all actions, regardless of the cause and of the time of discovery of the injury instead of the present unlimited period.

The HMA Bill (HB 638, H.D. 1) A Bill for an Act Relating to Limitations of Actions in Medical Malpractice Cases, which passed the House in the 1971 session was transmitted to the Senate for action as a carry-over bill in the present 1972 session. By requirements of the State Constitution a carried bill required one further reading in the house of its origin. Due to the great number of legislative measures being handled by both houses of the Legislature on the final day of the session, House Bill 638, H.D. 1 was not returned to the House of Representatives in time for the one final reading required for its enactment.

We therefore had an anomalous situation where House Bill 638, H.D. 1 still failed to be enacted into law despite having passed both houses of the Legislature.

I would like to note here that the Director of Regulatory Agencies, in his report in response to Senate Resolution 222 (Sixth Legislature, 1971 Session) recommended legal reform in the area of the statute of limitations and supported enactment of House Bill 638.

Although HB 638 did not pass this session, I believe sufficient work has been done by the Hawaii Medical Association to merit favorable consideration of this measure for the next year.

BEN F. KAITO

Legislative Counsel

Your Reference Committee next considered the report of the Legislative Counsel and recommends approval of the report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE

The Legislative Committee began meeting regularly in December, 1971 to consider bills in the Sixth State Legislature which are of concern to the medical profession. Because of the accelerating malpractice crises of a very complex nature confronting the medical profession, the Legislative Committee (with the concurrence of the Council of the HMA) voted to continue to retain Mr. Ben Kaito as our Legislative Counsel for the current session of the Legislature.

The Legislative Counsel's report will contain a summary of the action taken in this area as well as his activity for the Association in other areas. Of particular concern to the Association during this session of the Legislature is H.B. No. 638 relating to the limitation of action in malpractice actions. As everyone in the medical profession knows, the present law provides no period of limitation within which action for a medical tort must be brought. As this report is being prepared H.B. No. 638 appears to have a good possibility of being enacted.

Of great importance to the medical profession is the enactment of the bill establishing the age of eighteen years or older as the age of legal capacity and responsibility. The Association strongly supported this bill. In addition, the Association recommended that minors fourteen years of age or older be given the legal capacity to consent to medical care for family planning services and substance abuse. We are anticipating agreement by the conference committee of the House and Senate on H.B. No. 766 which may lead to enactment of this important measure.

In addition to the bills mentioned above the members of the Association actively participated in drafting position statements and presented testimony at legislative committee hearings on the following issues: Environmental Health; Penal Code and Mental Health; Physician's Assistant, Para-medics; Four-year Medical School; Hospital Franchising; Prohibiting Contingent Legal Fee Agreements in Medical Malpractice Litigation; School Health and Related Bills; Mandatory Examination of Pregnant Women for Gonorrhea; Automotive Safety; Residency Requirements for Physicians and Workmen's Compensation.

Since lobbying is an intricate process that requires sustained effort, the policy of the Association to retain a legislative counsel from within the party in power is necessary. This is particularly true at the present time in our efforts to have bills enacted that will help relieve the accelerating malpractice crisis facing the medical profession. An important measure the Legislative Committee will be considering is a compulsory arbitration bill to resolve malpractice litigation. To pursue this measure successfully will undoubtedly require the expertise of our legislative counsel. No one in the Legislative Committee or the staff is capable of steering through a bill of this type.

BUDGET REQUEST:	
Legislative Counsel	\$6,500.00
Entertainment	1,000.00
Today's Health	190.00
Miscellaneous	100.00
<hr/>	
TOTAL REQUEST	\$7,790.00

RECOMMENDATIONS:
(1) That the budget of the Legislative Committee be approved as submitted

- (2) That the efficient services of the legislative secretary, Mrs. Becky Kendro, be acknowledged and that she continue to serve in this capacity
- (3) That the invaluable services of Mr. Ben F. Kaito be acknowledged and that his contract be extended for another year.

GEORGE GOTO, M.D.

Legislative

Your Reference Committee next considered the report of the Legislative Committee. We recommend approval of all Recommendations with the stipulation that the budget request be appropriated to the Commission on Legislation as outlined in the report of the Treasurer.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MABEL L. SMYTH BOARD OF MANAGEMENT

The Board of Management of the Mabel L. Smyth Building held two joint meetings with the HMA Site Committee to discuss the feasibility of providing additional space for the HMA and HCMS offices.

Architect Vladimir Ossipoff made several proposals, such as adding a floor over the Auditorium to provide 2,960 sq. ft. of floor space at a cost of \$140,000; or a two-story addition mauka of the Auditorium to provide 3,263 sq. ft. at a cost of \$170,000. The rental of the new space will be used to pay off the construction loan. These proposals were formally presented to the HMA Council but no action was taken.

The Nurses & Physicians Exchange gained 18 new subscribers this year and averaged 24,215 calls per month.

CARL H. LUM, M.D.

Mabel Smyth Board

Your Reference Committee heard discussion on the report of the Mabel Smyth Board of Management and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MAUI COUNTY

During 1971, the Maui County Medical Society held nine meetings, in addition to our annual Christmas party during December; attendance averaged 40% of our 49 members. Seven of the meetings were preceded by a scientific program featuring an off-island visiting speaker.

The highlight accomplishment of the year was the formation of Hawaii's first Health Maintenance Organization on Maui. Preliminary groundwork was done by the Society with the goal being the inclusion of all interested members of the Society in the HMO. However, during subsequent negotiations with H.M.S.A., that insurer expressed willingness to contract only with an established group of physicians. Therefore, with the knowledge and blessing of the Society, the Maui Medical Group HMO insured by H.M.S.A. was formed and marketed in December 1971.

Our Society-sponsored Medical Explorer Post was continued during the first half of the year with 27 members, ten of whom attended the February AMA Careers Day in Honolulu at our expense. In September, the post was reorganized by Dr. Romero (advisor), including 15 new members, meeting regularly every other week and even spending some time in physicians' offices.

Our annual Diabetes Detection Drive was again held for three weeks, during the Christmas shopping season (December 2-18), testing a total of 1,403 Mauians, detecting 18 possible diabetics to be referred to their physi-

cians for definitive diagnosis, and discovering 11 new diabetic patients.

Involvement of the Society in community health activities continued by co-sponsoring the Maui Drug Abuse Conference in March, the Maui Symposium on Grief and Death, and the Maui Forum on Emergency Health Services. The AMA Speaker's Bureau honored us by holding an excellent speakers workshop on Maui in September, which was unfortunately attended by very few physicians.

Our Adjudication Committee actively reviewed claims submitted for review by Medicare and also reviewed Maui applicants for malpractice insurance with the Argonaut Insurance Company. It also set up a procedure for review malpractice suits against Maui members upon request of one of the attorneys.

Changes in our Bylaws were drawn up to set up a mechanism for peer review and opening membership in our Society to all licensed Maui County physicians; these changes were proposed in November for action in early 1972.

The year was brought to a successful conclusion with an extremely enjoyable "best-ever" Christmas party at the new Maui Surf Hotel, most capably arranged by our incoming President and Mrs. Denis Fu.

J. MARK B. SOWERS, M.D.

Maui County

Your Reference Committee next considered the report from Maui County and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NATIONAL LEGISLATION

The Committee has not been active this year because very few bills of a critical nature were introduced. There was the usual re-introduction of various legislation pertaining to National Health Insurance. These had already been discussed and the Hawaii Medical Association has already taken a stand on many of these issues.

The only important issue at present is an attempt to introduce legislation to create an Armed Service's Medical School. The AMA already has taken a firm stand against this proposal.

At times, this Committee seems superfluous because by the time the "Legislative Roundup," and the "Weekly Report on National Medical Legislation" is received, representatives of the AMA have already testified on the bills in Congress. While all the members should be cognizant of what is going on as far as national legislation is concerned, I do not feel that a meeting is necessary unless the AMA requests that we take a stand and notify our Congressmen and Senators of our stand. Also, if the AMA takes a stand that we feel is incorrect, we should meet on that particular problem.

L. Q. PANG, M.D.

National Legislation

Your Reference Committee next considered the report of the National Legislation Committee and recommends approval of the report.

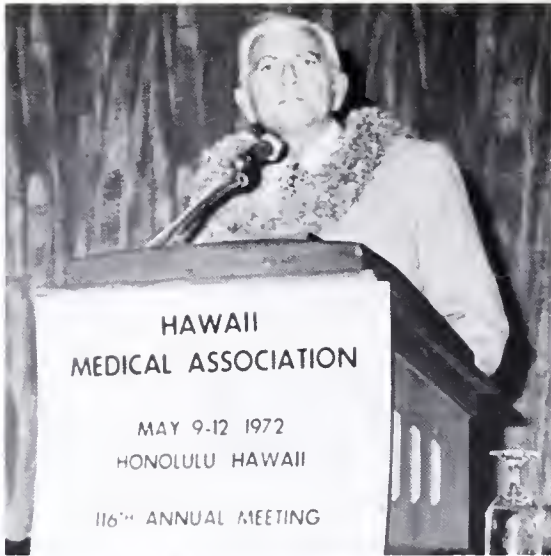
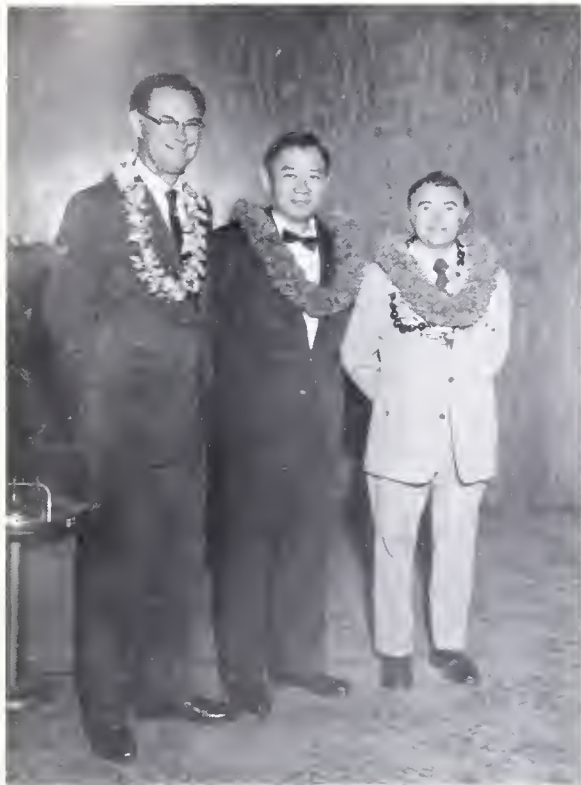
ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT

Since assuming the highest office in our Association a few months ago, it has become apparent that in order to be effective in carrying out the duties of this office,

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the President must spend at least half of his working hours in the Association office or attending meetings in the community. To be a more effective organization, many Council meetings were held. Officers or Executive Board meetings were generally held every second and fourth Friday of the month beginning at 7:00 A.M.

Invited to these Executive Board meetings were the commissioners of your organization, chairmen of the Bureau of Research and Planning and Public Relations Committees, officers of the counties, the AMA Delegate and Alternate Delegate, the President's Assistant, administrative staff and any concerned members. These meetings were well attended and indeed helpful to your officers. The commissioners lifted the burden from the shoulders of your officers by keeping them informed of the work of the committees, and they helped to create an effective table of organization.

To the House of Delegates goes our gratitude for supporting the request for an Assistant to the President at its last annual meeting.

During the past few years, the space situation in the Association has been getting tighter and tighter. The mechanism needs to be started immediately to correct this situation. Our personnel needs more space for greater efficiency. Your President and his Assistant need more space of their own. Communications to your officers are filed in folders located partly in the Executive Director's office and partly in space among the secretaries and clerks. The space and facilities at present allotted to your President are most conducive to producing a non-productive President.

During the past year, your Association has (1) become more deeply involved in the quality of care study by the development of EMCRO, (2) is proceeding with its own reorganization plans, (3) is becoming involved with the development of the Cancer Research Center at the University of Hawaii, and (4) has submitted a grant request to Regional Medical Program of Hawaii to develop an Emergency Medical Service System for our State. To be progressive, your Association needs to be aggressive. To keep our Association abreast of national trends, we should encourage our key members to participate in national conferences and encourage them to implement measures to the best interests of the Association and/or community.

There are several areas in which your Association must become more involved, but the two that are of highest priority are manpower development and peer review. The former needs the cooperative effort of the medical and nursing schools, hospitals, community organizations and your Association. The latter must be developed immediately, and should lead to the creation of a Professional Standards Review Organization (PSRO). To this end, the Hawaii Foundation for Medical Care should now be placed under the auspices of our Association, and it must become more active. There should be a re-evaluation of its goals and structure, and membership in the Hawaii Medical Association should not be a requirement to participate in the Foundation. To be more effective there should be some affiliation with the hospitals.

Your Association should continue to develop close ties with the hospitals, the medical and nursing schools, and legislature, so that these bodies will look to your Association as a key organization in medical matters. The Association should function closely with Comprehensive Health Planning, Regional Medical Program and Health and Community Services Council, keeping abreast of national and local developments in the health field and provide guidelines to these bodies. Our Association should aid the county societies in their plans to meet the health needs of their area, and be actively involved in planning on federal and local levels.

RECOMMENDATIONS:

- (1) Creating the office of the Executive Vice President, this physician to be appointed by the

President and the salary to be determined by the Executive Board. The Executive Vice President shall be an ex-officio, non-voting member of all committees of the Association.

- (2) Allotting space and equipment for the President and the Executive Vice President.
- (3) Moving to adequate facilities for more efficient and effective functioning of our Association and to provide needed space for expansion of our present and anticipated projects.
- (4) Constitutional meeting by the House of Delegates in September or October 1972 to implement the reports of the Commissioner on Commissions and the internal reorganization of this Association and consider any other matter that may be vital to the organization.
- (5) Immediate development of a system of state and county inter-related peer review.
- (6) Encourage Honolulu County Medical Society to transfer the Hawaii Foundation for Medical Care to the Hawaii Medical Association.
- (7) Meetings of your Executive Board with hospital and medical school representatives to insure smooth coordination in the development of programs.
- (8) Working closely with medical, governmental and private bodies, taking the initiative when indicated in developing means of reaching the Association's goal of optimum health for Hawaii's people.
- (9) Committees recognize their responsibility to provide expert advice to the Executive Board on subjects within their scope.
- (10) Encourage Hawaii Medical Association appointees to boards or agencies outside the Hawaii Medical Association to submit regular reports on matters of concern to the Hawaii Medical Association.

To you all, many thanks for having enriched my life by permitting me to participate so actively in our Association by being your President this year. My thanks to our dedicated and hardworking staff, the Executive Director, my very able, efficient and knowledgeable Assistant, the Commissioners, committee chairmen, and members who have helped to guide the destiny of your Association. Finally, to you members who have been so loyal in helping me sustain my practice, in overlooking some of my tardy consultations and in seeking means to make me more efficient, my eternal gratitude.

HERBERT Y. H. CHINN, M.D.

President

Your Reference Committee next considered the report of the President and commends his untiring and inspirational leadership during the past year. In reviewing the report, your Committee recommends that paragraph 3, with the exception of the first sentence, be deleted from the report. It is also recommended that the first Recommendation be deleted and the following substituted: "The Assistant to the President shall be appointed by, and be directly responsible to, the President of the Association. He shall act on behalf of the President, representing him, or the Association, in such community and professional activities and forming such liaisons as the President may designate. He shall be an ex-officio, non-voting member of all committees, but shall be a voting member of any committee to which he is appointed by the President, in which case he will serve as an individual and not as the representative of the President. The Assistant to the President shall be a member of the Hawaii Medical Association. The officers shall be instructed to outline the duties of the Assistant to the President through a job description." In Recommendation 2, the reference to "Executive Vice

President" should be deleted and Assistant to the President substituted. Recommendations 7 and 9 should be corrected to read "officers" in place of "Executive Board." In Recommendation 10 we recommend the first word of the sentence be changed to "Require." We recommend approval of Recommendations 3, 4, 5, and 8 as presented. Your Committee recommends approval of the report as amended.

ACTION :

The Chairman moved adoption of this portion of the report. A motion was made and seconded that Recommendation No. 5 be amended by placing a period after the words "peer review" and deleting the remainder of the sentence. The amendment was passed. The report was adopted as amended.

SECRETARY

The total active membership of the Association as of December 31, 1971, was 825, an increase of 36 compared to December 31, 1970, which was 789. The inactive members numbered 26, an increase of 5 over the previous year. Of the 825 active members, 70 were granted dues waiver, a decrease of five over the previous calendar year.

A total of 87 unlimited licenses were issued in 1971. Temporary and limited licenses were issued to 204 physicians compared to 187 in the previous year.

Eight members died in 1971: Edmund L. Lee, Harry L. Arnold, Sr., Clarence L. Carter, Robert H. Lee, Francis F. C. Wong, Henry B. Yuen, William B. Short, Jr., and Donn R. Grininger.

Unaffiliated physicians were reported by the counties as follows: Hawaii (not reported), Honolulu, 341, Kauai, 2, and Maui, 7.

By counties, the active membership was made up as follows as of December 31, 1971:

COUNTY	ACTIVE DUES	ACTIVE DUES	TOTAL
	PAYING	WAIVED	
Hawaii	46	7	53
Honolulu	640	55	695
Kauai	25	3	28
Maui	44	5	49
TOTAL	755	70	825

Since the last annual meeting there have been seven Council meetings. These were held on May 28, August 20, November 12, January 7, February 25, March 17, and April 14.

At the May 28 meeting, the Council considered the AMA Medicaid bill and asked the National Legislation Committee for their recommendations. The Ilikai Hotel was approved as the site of the 1972 Annual Meeting if the Ilikai is able to provide the most economical and suitable facilities. Officers of the Community Research Bureau were elected as follows: B. A. Richardson, President; Theodore T. Tomita, Vice President; O. D. Pinkerton, Secretary; and Herbert Y. H. Chinn, Treasurer. The Site Committee presented a progress report on new or additional space for the HMA-HCMS offices but the Council felt they needed additional information before taking action. Guidelines for the Professional Liability Committee were approved. The Council agreed to approach the Governor's Office in an attempt to release the Workmen's Compensation Fee Schedule and voted to join with the Neurological Society and the Association of Medical Clinics in filing a writ of mandamus if the schedule was not released within a two-week period from the date of the meeting. Members of the Bureau and Finance Committee were approved. The Council voted to express their appreciation to Dr. Alex Anderson for his assistance in preparing the grant for EMCRO (Experimental Medical Care Review Organiza-

tion). It was noted that the HMA grant has received preliminary approval. The Council voted to send two representatives to San Francisco for the EMCRO site conference. A job description and table of organization for the Assistant to the President was approved and the President was authorized \$500 for the position of Assistant to the President subject to review by the Council at the end of the fiscal year. The 1970 RVS was approved for use as of March 1, 1971 and it was voted to so inform the HMA membership. An increase in the rate of per diem for employees was raised from \$35 to \$50 per day for those who travel on HMA business. It was voted to remind commissioners, committee chairmen, and committee members of their responsibilities and the limits of their authority. Names were submitted to President Cleveland of the University of Hawaii for the Search Committee for Selection of Dean of the School of Medicine. Names from the past and present HMA and HCMS presidents were submitted to the AMA for their Directory of Federal Advisory Posts.

The August 20 Council Meeting was primarily devoted to discussion of the newly promulgated Workmen's Compensation Fee Schedule. The Council heard testimony from the membership and voted to appeal the Regulation. It was also voted to prepare legislation which would incorporate the usual, customary, and reasonable concept in the present statutes as well as provide for the elimination of any artificial division of classes of physicians. The Council took action on various sections of the schedule and authorized the HMA President to call a special meeting of the House of Delegates when in his judgment there was cause to do so. A report on the formation of an HMO on Maui was presented. The President was authorized to search for funds to study the cost of medical care. The Executive Committee was authorized to make appointments of chairmen and membership on committees of EMCRO. A press release relative to the HMA Study on the Quality of Care was deferred until Dr. Anderson's return and the press release determined by Dr. Anderson and the Executive Committee.

At the November 12 Council Meeting, last year's policies regarding registration fees and dues waiver categories for the 1972 meeting were accepted. A motion whereby any minor, 16 years of age or older, can consent to medical care and services was not passed. A joint statement by the DOH and HMA, re. recommendations for a comprehensive program to combat venereal disease will be submitted to the Legislature. A Committee composed of five past presidents and chaired by Dr. George Mills was formed to review the AMA Evaluation of HMA and make recommendations to the Council. This Committee was allowed \$500.

At the January 7 Council Meeting, a letter of endorsement for continuation of the Regional Pediatric Pulmonary Program was approved. The Blood Bank was urged to purchase a Blood Cell Separator. HMA's Committee on Underprivileged Medical Care was directed to meet with DSS regarding the usual and customary fees. The Annual Banquet will be held at the Ilikai on Friday, May 12, and Sportsmen's Night on Saturday, May 13, at a different locale. The HAWAII MEDICAL JOURNAL subscription rate was raised to \$8.00 per year subject to legal approval. Mr. Ben Kaito was retained as HMA's Legislative Counsel. The Council reconsidered the Minors Consent Bill and approval was given for minors 16 years and older to consent to family planning services but excluding surgery. Dr. Sehnack and Dr. deJesus were appointed HMA representatives to the Hawaii Association of Professions. The Council opposed two proposals to the Hawaii Revised Statutes relating to: (1) the requirement of reporting cancer cases, and (2) the Cancer Advisory Committee to the Tumor Registry. The Council expressed concern over the Phase II Price Controls and voted to incorporate this concern in letters to the Federal Price Commission, President of the United States, Hawaii's Congressional Delegation, the AMA and HMA membership. The Council voted to consider only requests

from medically-oriented organizations for financial contributions and endorsements, leave personal endorsements to the discretion of the doctor. The continuation of the position of Assistant to the President was left to the President's discretion. Mr. Thorson and Mr. Won were directed to study the suggestion to summarize committee reports and correspondence for neighbor island officers.

At the February 25 meeting, the Council voted to write a letter of endorsement for a proposed Kui Lee Cancer Fund which lends support in an appeal for contributions for cancer research projects. The Bureau of Research and Planning, after studying the overall cancer program in the State, made recommendations to the Council to present to the House of Delegates in May. A motion was passed that the HMA Council reaffirm the fact that HMA inaugurated the Hawaii Tumor Registry and that it remain under the jurisdiction of the HMA, and recommend to the House of Delegates that membership on the Cancer Commission be enlarged by two members nominated by the President of the University of Hawaii who are members of the HMA and Medical School faculty. It was also passed to direct HMA's representative on the Ad Hoc Policy Task Force of the Cancer Research Center to request or work toward community representation on the Executive Board. It was voted to advise the University of Hawaii President of the action regarding the composition on the Cancer Commission and the feeling that the Executive Board of the Cancer Research Center be community oriented.

The Council denied a request to use EMCRO criteria for a research project at the March 17 meeting. Dr. E. Anderson was asked to study a proposal for determining fee studies. The TV-Radio Committee's request for a supplemental budget for the balance of 1972 for "H.M.A. HOTLINE" was referred to the Finance Committee for further review. The proposal of initiation rites for new members of the State Association and county societies was tabled indefinitely. Dr. Sakamaki was granted permission to attend the AMA Council on Environmental Health and Public Health meeting and was requested to submit a report of this meeting. HMA voted to participate in the "Comprehensive Program to Combat Venereal Disease." Dr. Sia was granted approval to testify at a public hearing on the Department of Education's Three-on-Two Program. The Council did not endorse the drug abuse booklet, "Guidelines to the Perplexed," because it contained certain flaws. Support was given to SB 1613 and SB 1614 relating to mobile intensive care paramedics. The Maui delegation was instructed to approach the By-laws Committee to propose necessary changes for osteopathic membership and qualifications. HMA reiterated that EMCRO is a HMA project and dispositions on EMCRO findings and data must be approved by the HMA as provided in the contract with Dr. Alexander Anderson. The Council voted that DSS should be advised that although a conversion factor of five was accepted years ago, physicians should be reimbursed on a usual, customary and reasonable fee basis.

At the Budget Council Meeting on April 14, the Council appointed the President-elect to select a committee to review the Episode of Illness and Office Care Studies and to make recommendations to the Council or House of Delegates. Approval was given to use EMCRO criteria to evaluate cervical strain. The Watumull Fund will be asked to again appropriate scholarship monies for the U.H. Medical students. The HMA Council was given approval to implement and establish committees on an ad hoc basis according to recommendations from the Committee on Commissions. The proposal that the Cancer Committee be a separate committee under the Public Health Commission failed to pass. Dr. Goto was given a vote of thanks for his legislative work. "Clinical Pharmacology and Therapeutics" was voted as the theme of the 1973 Annual Meeting. The Council voted to review and discuss many of the major decisions and changes embodied in the AMA Study Committee report at a special meeting of the House of Delegates. Approval was given to the Emergency Medical Service project of HMA.

It will be recommended that the House of Delegates appropriate \$20,000 for legal fees for the Workmen's Compensation legal suit. The following budget alterations were recommended to the House of Delegates: (1) that the TV-Radio Committee be appropriated only funds presently budgeted for 1972 and a limit of \$7,500 for 1973, (2) that \$12,000 be appropriated for the position of Assistant to the President but subject to approval by the President and the Executive Committee, (3) that the income from projects be allocated to the organization that generates it and that the costs be allocated according to the percentage of utilization. The 1973 budget requests were accepted with the proper changes. Dr. Grover Batten was nominated as the HMA representative to the Mabel Smyth Board.

The dates for the 1973 Annual Meeting have been tentatively set for May 9-12 at the Princess Kaiulani Hotel.

RECOMMENDATION: That the Council be granted permission to change the sites and dates of the annual meeting if unforeseen events develop to make the change advisable.

R. VARIAN SLOAN, M.D.

Secretary

Your Reference Committee next considered the report of the Secretary and recommends approval of the report and its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SITE

The goal or objective of this Committee is actually two-fold:

(1) To determine the necessity of relocation of the executive offices of the HMA, HCMS and BME.

(2) To determine the feasibility of the relocation of the HMA and HCMS from the Mabel Smyth Building and if possible to accomplish this, how it could be done without continued financial support of the Mabel Smyth Building.

A. After perusal of the awkward present physical relationship of the three, particularly of the BME and its location, the inefficient use of personnel and poor coordination of the efforts of all three, it is obvious that a consolidation of these three organizations into one physical plant or location is desirable. The space in our present location is totally inadequate to accomplish this objective.

B. Alterations to the present Mabel Smyth structure to give us adequate additional space would cost in the neighborhood of \$150,000, which would provide about 3,000 extra feet of space by *decking the existing Mabel Smyth Auditorium*. However, the present space in Mabel Smyth used by HMA and HCMS is not adequate and/or very poorly arranged and a modification would cost in the area of \$15,000 to \$20,000. If these two things were accomplished, we would then probably be able to operate for a limited period of time. Inadequacy of parking exists now and with the addition of the BME our problem would be compounded.

Careful consideration has been given to many other locations and a cost estimate has been made regarding rental, purchase of a condominium and erection of our own building on fee simple land, as well as limited partnership on fee simple and/or leased land.

Rental space would come to between 60 and 70 cents per sq. ft. and with the requirement of 6,000 sq. ft., our monthly rental bill would be \$3,600 or more. The Committee does not feel that such expenditure without ob-

taining equity in a building is desirable nor does it constitute sound business practice. (In one out of several locations studied (Control Data Building) the parking was adequate on the basis of the square footage we would rent.)

For the purchase of a condominium, a ball-park figure of \$65.00 or \$75.00 per sq. ft. for construction of such a facility would be \$390,000 or more, on the basis of the required 6,000 sq. ft. This area is the Kukui area (HRA) in a block zoned for commercial use.

To erect our own structure on fee simple land would be equivalent to over \$400,000 plus the price of the land. Fee simple land runs from \$12.00 to \$20.00 and up per sq. ft. in areas considered handy to our Association. To erect our own structure on one site considered (fee simple land at \$12.00 per sq. ft.—20,820 sq. ft.) would probably be \$400,000 plus—plus land cost of \$250,000—total \$650,000.

The Limited Partnership concept is another approach where equity would be gained but costs are variable depending upon the use of fee simple land or leased land.

Fee simple—one very desirable location is on Vineyard near Queen Emma (six story building). Our space requirements (6,000+ sq. ft.) would consist of two floors (6,300 sq. ft.) and represents 35% of the building and land. Land acquisition costs (already purchased by main partners who will occupy space in the building) would total \$87,500 for our organization. (Total land cost \$250,000.) The cost of construction is estimated at one million dollars. Our share (35% of space) would be \$350,000. (Parking would allow us 12 stalls for two floors. Municipal parking available on Vineyard Street.) (Estimated maintenance cost for common areas of building—our share \$0.74 per sq. ft.)

Leased land (75 years)—Located on Makai side of Queen Street between Melim Building and HGEA Building across from Federal Office Building. (11 story building) 6,000 sq. ft. would require an equity subscription of \$26,400. Occupancy costs will amount to 60 cents per sq. ft. (\$3,600 per month). (Based on 40 cents for debt servicing and 20 cents for utilities and janitorial services.) Parking would be allocated on the basis of three stalls per 1,000 sq. ft. at \$30.00 per stall. (6,000-8,000 sq. ft. equals \$480 to \$720 per month for parking.)*

Our Committee was unofficially given the task of studying the possibilities of vacating the Mabel Smyth properties without having to maintain it. The only solution to this problem would be to obtain renters to use the space that we now occupy. This is possible, but it would appear that such renters would want to have the space we now occupy as early as 1973. This would be too early obviously for us to complete our arrangements and have at our disposal a completed structure unless another alternative is found or we were to select the Limited Partnership arrangements on Vineyard Street. (Construction time—8 months.)

O. D. PINKERTON, M.D.

Site, Ad Hoc

Your Reference Committee next considered the report of the Site Committee and would like to commend the committee for its hard work. We also recommend that the committee continue in their present activities in attempting to locate a permanent site for our organization. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

* We would get back our original investment by depreciation and tax write off in about five years. Thereafter the investor would share in net earnings—estimated after tax return 24% on equity.

TREASURER AND BUDGET REPORT

The presentation of the budget is prefaced necessarily by an analysis of the accounting and financial reporting of HMA during recent months.

You will find attached and in the following order, a Statement of our Income Items (Table 1), Statement of Expenses (Table 2), with a detail of Committee Expenditures supporting (Table 3). There are explanatory notes following Table 1 and Table 3.

Also included for demonstration purposes only is a copy of the breakdown of the regular report on the operation of the Common Fund (Table 4), so that it can be visualized and understood.

It is suggested that you read the material carefully. The changing pattern of HMA activities makes it mandatory that we apply certain open methods of budgeting to our committee allocations. At this point in time we do not know exactly what committees will be in existence in 1973. It is recommended that the council be given permission to make specific allocations of funds.

You will find that certain items are segregated differently than in previous budgets. The reason for this is based on the problem of having a separate operation within a joint staff and housing situation. Certain functions are solely those of the HMA, others are sole function of HCMS and still others depend on the joint use of facilities. The operating costs of HCMS functions are not reflected in this budget.

After you have read the first section of the material, then and only then, go over the budget itself. This is a deceptively simple document reflecting the 1972 estimated experience and projecting the 1973 anticipated requirements. The details of the various items are to be found in the preliminary statements.

Following the budget itself are some additional exhibits. These consist of current statements of the status of the Physicians Benevolent Fund, the Employees Retirement Plan, and the operation of the EMCRO project. They are included for your information.

You may feel that committee budgets are inadequate, but it must be remembered that meetings, travel, and support services are not met from the committee funds, but from other sources.

A word about Federally funded projects is in order. The EMCRO project will return certain funds to HMA for administration. These funds are to offset costs of running the project but not the project operation itself. Some of these costs are reflected directly in the over-expenditure of some budgeted items in the administrative budget. You will find this, for example, in item 11, Table 2, under the name of "Special". Telephone costs, item 10, Table 2, is another.

We must remember that such funding is not perpetual.

THOMAS P. FRISSELL, M.D.

TABLE 1.—Income items—1972.

ITEM	1972 BUDGET	1972 ESTIMATED
1. Dues	\$103,000.00	\$103,000.00
2. JOURNAL	30,600.00	33,400.00
3. Annual Meeting	23,800.00	24,600.00
4. Roster	10,300.00	12,500.00
5. Interest	3,200.00	3,000.00
6. Miscellaneous	1,200.00	1,800.00
TOTAL	\$172,100.00	\$178,300.00
7. EMCRO		40,000.00
		\$218,300.00
8. Possible TV Grants		15,000.00
		\$233,000.00

NOTES:

1. The income from dues is anticipated to be as originally estimated. It is predicated on slightly less than 750 paid members.
2. We anticipate receiving a higher than estimated revenue from the JOURNAL because of an increase in the subscription rate and an increase in the advertising rate.
3. Annual Meeting revenue appears to be running ahead of our original estimates. We have a larger exhibit space than heretofore and there is an increase in mainland registrants.
4. The Roster advertising revenue is up. The sale of Rosters will be above that of former years.
5. Interest revenue will drop. It was necessary that we liquidate a number of savings accounts during the latter part of 1971.
6. Miscellaneous income items not otherwise classified, such as the charge for addressing envelopes, etc., is on the increase.
7. EMCRO income as reported here will be the reimbursement for the indirect costs of the project. The indirect costs are based on a provisional rate of 29.2% of project costs of about \$137,000, through May, 1972, with an unknown amount for the balance of the year.
8. It is possible that the continuation of the "HMA HOTLINE" (formerly "Medically Speaking") will be dependent on obtaining outside funding. It is hoped that this can be realized through private foundations.

TABLE 2.—Report on 1972 expense items.

ITEM	1972 BUDGET	ESTIMATED 1972
1. Commission Internal Affairs	\$ 190.00	\$ 190.00
2. Education & Scientific Research	300.00	500.00
3. Public Health	-----	-----
4. Public Relations	10,845.00	10,845.00
5. Legislative	7,750.00	7,750.00
6. Medical Services	5,500.00	20,000.00
TOTAL	\$ 24,585.00	\$ 39,285.00
<i>HMA Direct Costs</i>		
7. Travel	\$ 7,000.00	\$ 6,000.00
8. HAMPAC	200.00	200.00
9. Meetings	4,300.00	7,000.00
10. Telephone & Telegram	1,600.00	3,600.00
11. Special	1,000.00	3,000.00
12. Contingency	700.00	700.00
13. Postage	3,000.00	2,000.00
14. Audit	3,000.00	1,800.00
15. Auxiliary	4,200.00	4,200.00
16. Taxes	500.00	500.00
17. Council	1,200.00	1,500.00
18. Library	100.00	100.00
19. Depreciation	600.00	600.00
20. Miscellaneous	1,300.00	1,300.00
21. Unbudgeted	-----	-----
TOTAL	\$ 28,700.00	\$ 32,500.00
22. JOURNAL	\$ 31,386.00	\$ 31,000.00
23. Roster	11,606.00	10,500.00
24. Annual Meeting	18,165.00	15,400.00
25. Common Fund	77,420.00	75,907.00
TOTAL	\$191,862.00	\$204,592.00

TABLE 3.—Details of commissions and committees 1972 budgets.

	1972 BUDGET	1972 ESTIMATE
1. Internal Affairs		
Arrangements	\$ -----	\$ -----
Awards	190.00	190.00
Bylaws	-----	-----
Scientific Sessions	-----	-----
AMA Clinical Meeting	-----	-----
	\$ 190.00	\$ 190.00
2. Education & Scientific Research		
Scientific Research	\$ -----	\$ -----
Hospital	-----	-----
Medical Education	-----	200.00
Publications	300.00	300.00
	\$ 300.00	\$ 500.00
3. Public Health—no budgets		
4. Public & Interprofessional Relations		
Association of Professions	\$ -----	\$ -----
Careers	500.00	500.00
Disaster	100.00	100.00
Filipino Speakers	-----	-----
Japanese Speakers	150.00	150.00
Health Manpower	-----	-----
Medicine & Religion	-----	-----
News Media	325.00	325.00
Operation Pacific	-----	-----
Public Relations	4,200.00	500.00
Quackery	-----	-----
TV-Radio	5,570.00	5,570.00
Woman's Auxiliary	-----	-----
	\$10,845.00	\$ 7,145.00
5. Legislative		
Legislative	\$ 7,750.00	\$ 7,750.00
National Legislation	-----	-----
Pharmacy	-----	-----
Professional Liability	-----	-----
	\$ 7,750.00	\$ 7,750.00
6. Medical Services		
Adjudication	\$ -----	\$ -----
Fee Survey	500.00	0
Underprivileged	-----	-----
Medical Care Plans	-----	-----
Negotiating	-----	-----
Peer Review	-----	-----
Workmen's Compensation	5,000.00	20,000.00
	\$ 5,500.00	\$20,000.00
TOTAL	\$24,585.00	\$39,285.00

NOTES:

In summary, as mentioned earlier, the Committee changes being considered may well affect the eventual outcome as to the detail of expenditure but the total results may well be about the same as the total estimate. The explanations follows:

1. The Commission on Internal Affairs has only one Committee Budget on Awards. This will be spent as budgeted. The Annual Meeting is budgeted separately.
2. The Commission on Education and Scientific Research has budgeted for a redesign of the JOURNAL under the Publications Committee.
3. There were no budgeted items for the Public Health Commission.
4. The Commission on Public and Interprofessional Relations has a real problem in the continuance of

- the TV program formerly known as "Medically Speaking." Production costs will be assessed against the program following the shift to a commercial station from ETV.
- The Commission on Legislation will spend about what they planned.
 - The Commission on Medical Services has a problem in connection with the prosecution of the suit against the Department of Labor over the Workmen's Compensation proposal of the revised Rule XXXI. This was budgeted last year at \$5,000.00, but it is probable that the total cost of the suit may run to \$20,000.00.
- The section on HMA Direct Costs includes some committee expenses. In 1971, provision was made for travel of undesignated committee chairmen. This travel is charged to the general travel account. The cost of meals for committees is also charged to the general meetings account.
- The travel account includes both inter-island and mainland travel by officers and staff on HMA official business, as well as the travel by committee chairmen to authorized meetings.
 - HAMPAC includes the HMA contribution to the educational fund of HAMPAC.
 - Meetings include the cost of meals, etc., for committees.
 - The increased activity, particularly of the EMCRO project, has increased the need for telephone communication. The rate increase has also had its affect.
 - This was a special authorization for the implementation of the AMA Study report and also includes travel in connection with the report and travel for the President's Assistant.
 - The President's Contingency fund to be used at his discretion.
 - Postage costs are being conserved by combined mailings, etc.
 - Audit costs should be reduced this year because of internal changes resulting in a balanced situation requiring only the review by the auditors.
 - The dues to the Auxiliary will be as anticipated.
 - Taxes on particular portions of the payroll for strictly HMA personnel costs such as the JOURNAL will be as expected.
 - Council meetings will run above budget because of increased frequency of meetings.
 - The contribution to the library is the same.
 - Depreciation reserves will have to be increased in 1973 because of additional equipment, but the 1972 item will be stable.
 - Miscellaneous items will run as expected.
 - Certain printing and supply costs were included in this category but are now in the Common Fund budget.
 - JOURNAL costs should be reduced. We are converting to the offset printing method and by the end of the year should be entirely changed over.
 - The Roster appears to be costing less than anticipated.
 - Certain savings were possible for the Annual Meeting by timing the events to avoid extra charges for use of the Ballroom. By holding the Annual Banquet as scheduled we avoided one extra day charge for the room.
 - The Common Fund through which common expense items to both HMA and HCMS is holding to its estimates pretty well. It is probable that we will come in under the budget. This fund is the overall administrative fund and the detail of its operation will be found in Table 4.

TABLE 4			
COMMON FUND EXPENSES	CURRENT MONTH	TO DATE	1972 BUDGET
Salaries	\$4,502.08	\$ 9,291.43	\$54,000.00
Auditing	.....	.....	.....
Auto Allowance	45.19	85.19	600.00
Computer Reports	13.22	30.74	.....
Dues and Subscribers	.....	.....	.....
Insurance and Bond	49.56	534.47	1,500.00
Lease Rent on Office Equipment	110.85	169.11	.....
Office Supplies (Central)	265.96	526.08	3,000.00
Postage	.....	15.00	.....
Rent	630.07	1,260.14	7,560.00
Repairs and Maintenance	.....	40.56	300.00
Retirement	.....	.....	4,000.00
Telephone and Telegram	25.41	45.88	400.00
Taxes (FICA, U/C, FUTA)	249.05	392.60	2,500.00
Travel	.....	.....	2,000.00
Legal and Professional	130.00	260.00	1,560.00
TOTAL COMMON FUND	\$6,021.39	\$12,651.20	\$77,420.00

Budget Projections for 1973:

We have not yet had a full year of experience under the joint funding of staff activities. The accounting year of HMA was changed to the calendar year effective January 1, 1972. This resulted in a half year from July 1, 1971, to December 31, 1971, and whereas the great bulk of income to HMA occurs during the first half of a calendar year, the last half of 1971 reflected a considerable deficit.

The projections for the balance of 1972 are based on the estimates from the committees and the known rates of expenditure for the early part of 1972 and the last months of 1971.

Shown on the consolidated budget sheet are the figures that relate to our current committee and commission structure. Supporting documents reflect the details that go into the consolidated budget. With the strong possibility of a major change in the committee structure it is probable that there will be major adjustments in the budget during the final half of 1972 and that this proposed budget (for 1973) will have to be revised after the meeting of the House of Delegates.

The Treasurer's report gives a clear picture of 1972 estimated financial activities. Predicated on those figures with some adjustments for rising costs is the 1973 budget.

In view of the uncertain committee structure, this budget is submitted in more or less lump sum fashion, taking into consideration the known activities and committee requests as well as the probable committee changes in the form of consolidation, and/or elimination of some committees.

1973 BUDGET REQUEST:		
	1972 ESTIMATES	1973 RECOMMENDATIONS
<i>Income Items:</i>		
Dues	\$103,000.00	\$108,000.00
JOURNAL	33,400.00	35,000.00
Annual Meeting	24,600.00	28,000.00
Roster	12,500.00	12,500.00
Interest	3,000.00	3,000.00
Miscellaneous	1,800.00	2,000.00
	\$178,300.00	\$188,500.00
EMCRO	40,000.00	50,000.00
TOTAL	\$218,300.00	\$238,500.00

1973 BUDGET REQUEST:

Expense Items:	1972	1973
Commissions and Committees	ESTIMATES \$ 39,285.00	RECOMMENDATIONS \$ 32,000.00*
HMA Direct Costs	32,500.00	35,000.00
President's Assistant	-----	12,000.00†
JOURNAL	31,000.00	31,000.00
Roster	10,500.00	12,000.00
Annual Meeting	15,400.00	17,500.00
Common Fund	75,907.00	81,000.00
TOTAL	\$204,592.00	\$220,500.00

* Non-recurring item of legal costs of Workmen's Compensation suit included in 1972 figure but not in 1973 figure.

† The House of Delegates approved the position of "President's Assistant" at the 1971 meeting. No provision was made in the 1971 half year budget nor was it provided for in the 1972 budget. The cost of this position is being met through other budgetary items by reallocation of costs.

The line item appearing in the 1973 budget, specifically identifies this position and provides for the funding.

The line item appearing in the 1973 budget, specifically identifies this position and provides for the funding.

Hawaii Medical Association Physicians Benevolent Fund March 31, 1972

ASSETS:

Savings Fund:

American Savings & Loan Assn.	\$12,235.42
Pacific Savings & Loan Assn.	12,863.04
Maui Savings & Loan Assn.	11,604.20

TOTAL BENEVOLENT FUND **\$36,702.66**

Physicians Benevolent Fund:

This fund is static as far as the Principal Corpus is concerned. However, each year interest earning is generated from the savings in excess \$1,800.00 and increasing yearly due to the compounded interest. The total current funds of \$36,700.00 is now accumulated in the books.

HMA-HCMS Hawaii Medical Association Employees Retirement Funds March 31, 1972

	Book Value	Market Value
ASSETS:		
Cash in Hawaiian Trust Co.	\$20,721	\$20,721
Investments:		
Contract Equity Fund	\$34,615	\$37,927
Contract Fixed Insurance Fund	14,513	14,577
International Savings and Loan	500	500
Total Investments	49,628	53,004
TOTAL RETIREMENT FUND	\$70,349	\$73,725

HMA-HCMS Employees Retirement Fund:

The Employees Retirement Fund of Hawaii Medical Association and Honolulu County Medical Society was merged into the Hawaii Medical Association Retirement Fund as of January 1, 1972. This merger has increased the principal corpus funds to \$70,349. The inventory of Common Stocks of Honolulu County Medical Society for the sum of \$22,325 was liquidated and is reflected in the Hawaiian Trust Co. cash fund.

Hawaiian Medical Association Re: EMCRO

	ESTIMATES FOR 1972	GRANT BUDGET
INDIRECT CASH EARNINGS:		
<i>Receipts</i>	\$145,000.00	\$180,438.00
<i>Disbursements:</i>		
Salaries (Professional Services)	70,000.00	107,832.00
CPHA (PAS-MAP)	11,450.00	16,581.00
Consultants Fee	5,600.00	5,809.00
Computer Rental & Supplies	12,300.00	12,500.00
Office (Postage, Supplies, Etc.)	3,500.00	3,600.00
Seminar Expense & Data Prep.	12,500.00	12,000.00
Travel	10,750.00	10,116.00
Xeroxing	2,900.00	3,000.00
Equipment (Computer)	9,550.00	9,000.00
TOTAL DISBURSEMENT	\$138,550.00	\$180,438.00
NET	\$ 6,450.00	0

INDIRECT COST INCOME:

Total Disbursement of \$138,550.00 \times 29.2% = \$40,450.00.

Based on our provisional rate of 29.2%, the estimated reimbursement for Indirect Costs should be approximately \$40,000.00 for 1972 fiscal year.

Treasurer

Your Reference Committee next considered the comprehensive report of the Treasurer and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 4

Re: AMA Membership

WHEREAS, Chapter II, Section 1 of the current Bylaws of Hawaii Medical Association makes membership in the Hawaii Medical Association and the American Medical Association automatic for all members of component societies of the Hawaii Medical Association, and

WHEREAS, Chapter II, Section 8-e of the Bylaws of Hawaii Medical Association requires that all members of the Hawaii Medical Association be active or associate members of the American Medical Association, and

WHEREAS, the current Bylaws of the Hawaii Medical Association thus eliminate a freedom of choice compatible with the democratic form of government insured by the Bylaws, now therefore be it

Resolved, that the House of Delegates of the Hawaii Medical Association mandate the President of the Hawaii Medical Association to initiate the proper procedures necessary to effect a change in the Bylaws that would permit an individual Hawaii Medical Association member the right to elect or reject membership in the American Medical Association without thereby jeopardizing membership in the Hawaii Medical Association and a component society, and be it further

Resolved, that the requirements of Chapter XII—Amendments—be fulfilled in time to present the proposed Bylaws amendment to the 1973 House of Delegates for final action.

Submitted by MARION L. HANLON, M.D.

Resolution No. 4

This resolution concerns membership in the AMA. The testimony presented to the Reference Committee was that the resolution not be adopted.

ACTION:

The Chairman recommended that Resolution No. 4 not be adopted. It was moved and seconded that Dr. J. I. F. Reppun be allowed to address the House regarding the resolution. The motion passed. It was voted to allow Dr. Elisabeth Anderson the privilege of the floor. The motion passed. A letter from Dr. Homer Izumi regarding the resolution was read to the House of Delegates. A letter from Dr. George H. Mills, AMA Delegate, was read to the House of Delegates. It was voted not to adopt the resolution.

RESOLUTION NO. 5

Re: Membership by Qualified Osteopaths

WHEREAS, the 1971 Hawaii Medical Association House of Delegates requested recommendations regarding qualifications for membership of osteopathic physicians in the Hawaii Medical Association to be presented to the 1972 House of Delegates, and

WHEREAS, the President of the Hawaii Medical Association has delegated to the Maui County Medical Society the responsibility for formulation of these recommendations, and

WHEREAS, the Maui County Medical Society has considered various alternative recommendations, including those of the American Medical Association Board of Trustees Committee on Osteopathy, and

WHEREAS, the Hawaii Medical Association Bylaws provide each component society with the power to elect its own members, and they confer simultaneous membership in the Hawaii Medical Association and the American Medical Association to component society members; therefore,

Be It Resolved, that the Hawaii Medical Association hereby amends Article IV (Membership) of its Charter of Incorporation to change the limitation of membership from "doctors of medicine" to "qualified physicians," and

Be It Resolved, that the Hawaii Medical Association recommends a physician is qualified if

- (1) he is legally licensed without limitation of practice in the jurisdiction within which he practices,
- (2) he is practicing scientific medicine, in the judgment of the Admissions Committee, and
- (3) he agrees to abide by the Principles of Medical Ethics of the American Medical Association.

Submitted by MAUI COUNTY MEDICAL SOCIETY

Resolution No. 5

This resolution concerns membership by qualified osteopaths and your Reference Committee recommends the resolution not be adopted. However, there is a minority report from Dr. Sowers.

Minority Report of Resolution No. 5

This resolution was submitted to the House of Delegates, not to permit membership in our society by osteopathic physicians, because that is already possible after the 1970 amendments to our Bylaws (Chapter II and Section 1), but to set up some *minimum* standards for membership by any physician in a component society. The standards set forth in the second "Resolved" are those proposed by the American Medical Association Board of Trustees. Since each component society has the power to elect its own members with automatic simultaneous membership in the Hawaii Medical Association and the American Medical Association, the component society may utilize even higher standards of qualification if it desires, if this resolution passes. However, if this resolution does not pass, each component society may still admit *any licensed physician* and confer upon them automatic HMA and AMA membership, without having any guidelines to utilize in determining the applicant's qualifications! Therefore, the resolution is offered in an attempt to set forth some reasonable standards of membership other than a license to practice in the State of Hawaii.

ACTION:

In order to make the purpose of the resolution more clear, Dr. Sowers moved that the second "Be It Resolved" be amended to state "Be it resolved, that the Hawaii Medical Association recommends *as minimum standards* that a physician is qualified if . . ." The amendment was passed.

The motion to adopt the resolution as amended did not pass.

RESOLUTION NO. 12 AS ADOPTED

Re: Nursing Vacancies in Act 97 Hospitals

WHEREAS, the present slow-down in filling vacancies in the nursing and practical nursing staffs of the State Hospital System has produced nursing shortage beyond the tolerable, and

WHEREAS, in some hospitals, especially Hilo, closing of twenty-five percent of acute beds has reduced admissions to acute cases only, and

WHEREAS, slowing of the processing of applications to fill such vacancies has amounted to a freeze, and

WHEREAS, each vacant position has been treated like a new position request, with all the red-tape thereto attached, now therefore be it

Resolved, that the Hawaii Medical Association go on record as supporting easing of the reemployment of registered nurses and practical nurses so that the hospitals concerned can care for their patients, and be it further

Resolved, that the Hawaii Medical Association make every effort and exert every pressure to bring to a close the present situation threatening and compromising the health of citizens of the state, and to prevent its recurrence.

Submitted by DEWITT HENDEE SMITH, M.D.

Resolution No. 12

This resolution concerns nursing shortages and vacancies in the State Hospital System and your Committee recommends the resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 12 be adopted. It was voted to adopt the resolution as recommended.

INSURANCE AND MEDICAL SERVICES REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and received testimony on the various reports and resolutions referred to the committee for consideration and recommendation. Having given careful consideration to all the testimony presented, your Reference Committee is pleased to make the following report:

ADJUDICATION

It was not necessary for the Adjudication Committee to meet during the past year.

WILLIAM W. L. DANG, M.D.

Adjudication

Your Reference Committee first considered the report of the Adjudication Committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA CLINICAL SESSION, AD HOC

Planning progresses for the 1975 AMA Clinical Session in Hawaii. Representatives from the AMA have made on-site evaluations of the facilities in Hawaii and based on their report, the Board of Trustees have tentatively selected the Sheraton-Waikiki and Hilton Hawaiian Village for the major functions of the convention.

GEORGE H. MILLS, M.D.

AMA Clinical Session

Your Reference Committee next considered the report from the AMA Clinical Session, Ad Hoc Committee. Your Committee commends Dr. George Mills for his efforts in obtaining the 1975 Clinical Session to be held in Hawaii. Your Committee commends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA DELEGATE

The House of Delegates of the AMA deliberated over and responded to issues during 1971 that truly reflect the forces of change that are pressuring organized medicine.

Dr. Wesley Hall in his incoming president's address looked to the delegates and the AMA for more action. He requested the AMA "streamline our governing process to suit the needs and pace of the twentieth century physician and its people. He urged all physicians to come under AMA's umbrella and to bring us their hopes, their beliefs, their ideas, their vigor. His request for a constitutional convention was not adopted.

The House of Delegates continued its quest for involving more young physicians in the decision making process of the AMA by developing a section for interns and residents and a separate section for medical students. For the first time interns and residents will have a voting voice in the AMA.

The House of Delegates was enlarged by one when the Delegate from our neighbor, the Guam Medical Society, was seated as a delegate.

The health care delivery system was responsible for a great deal of deliberation at both the annual and clinical session. Peer review and PSRO legislation were high on the list of issues. It was reiterated that the practicing physician is the most qualified to render peer review service.

The House continued to support the pluralistic approach to the delivery of health care. HMO's could be a sound and integral part of this system. Government is being encouraged to critically review the results of their experiments with their 110 HMO's before forcing this system on the American public as a realistic and acceptable alternative to the health care delivery system of this country.

The physician's assistant and his role in the health care delivery system of the future received considerable discussion. It was emphasized that State and County medical societies must exert every effort and be involved when the classification and the scope of activity of these individuals is being developed.

The House also:

— directed the Board of Trustees and appropriate councils to study the cost of hospital services in consultation with the American Hospital Association.

— asked for immediate action by medical societies to improve the quality of emergency care.

GEORGE H. MILLS, M.D.

AMA Delegate

Your Reference Committee next considered the report of the AMA Delegate. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CARE FOR THE UNDERPRIVILEGED

Our Committee met with DSS officials to hear the current state and position of the DSS program. Like other State programs, they are caught in a tight budget squeeze and anticipate little change.

RECOMMENDATIONS:

- (1) The fee schedule negotiations with DSS should be placed in the hands of our Fee Survey Committee
- (2) Continue search for improvement in health care for underprivileged.

RICHARD MAMIYA, M.D.

Care for the Underprivileged

Your Reference Committee next considered the report of the Care for the Underprivileged Committee. Your Committee recommends that in Recommendation #1 the words "Fee Survey" be deleted and the words "Ad Hoc Negotiating" be substituted. Your Committee further recommends approval of Recommendation #2. Your Committee recommends approval of the recommendations as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH

This Commission presently consists of four committees: Medical Education, Hospital, Publications and Scientific Research. The major activities of each committee have been summarized in their reports.

The activities of the Hospital Committee should be commended since it initiated the development of closer liaison between the hospitals and aided immensely in the negotiations between the community hospitals and the University of Hawaii Medical School. This latter became a major HMA endeavor which was favorably received by all involved.

The Medical Education Committee has been an integral part of the HMA Experimental Medical Care Review Organization (EMCRO) project. While the end results of the EMCRO project may form the basis for continuing medical education, there is at present still no formal continuing medical education format utilized except through the scientific meetings at the annual meetings. The problems of continuing education are not unique to Hawaii and as yet no definite format to solve this problem has developed in the nation. The mandatory continuing education program of Oregon should be investigated and followed. As commissioner, I strongly urge that our Medical Education Committee study the AMA award system for continuing medical education and make recommendations to the next House of Delegates as to its utilization for HMA members.

The Committee on Commissions report will make a major change in this Commission. The inclusion of committees relating to peer review under this commission was intended to stress the role of education as well as discipline in the function of peer review.

RECOMMENDATIONS:

- (1) That the medical education committee study the AMA Physician's Recognition Award and make their recommendation of this method or an alternative method for implementation in the role of continuing medical education.

- (2) That the newly formed peer review committee be composed of appointees of the President and that each respective county medical society appoint one member to this committee.
- (3) That the peer review committee strongly consider the role of continuing medical education as one of the end results of peer review activities.

WINFRED Y. LEE, M.D.

Commission on Education and Scientific Research

Your Reference Committee next considered the report from the Commission on Education and Scientific Research. Your Committee recommends approval of all the recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON MEDICAL SERVICES

The commissioner attended most of the meetings held by the committees listed under Medical Services. The Fee Survey Committee, under the chairmanship of Dr. Nicholson, was very active, with discussions on the 1970 RVS revisions and additions; and, with HMSA sponsorship, a series of seminars on the use of the RVS. The Committee on Health Care of the Underprivileged held one meeting, on January 21, 1972, at the request of the HMA Council. The key problem is unchanged from last year, ie, no money available to increase the level of fees paid for services to DSS patients. Workmen's Compensation activities manifested themselves mainly at a March 7, 1972 HCMS meeting where Mr. Robert Hasegawa, Director of Labor, was available for dialogue. The other committees, ie, Adjudication, Medical Care Plans, Negotiating, and Peer Review, held no meetings.

RECOMMENDATION: That the HMA adopt the proposed revised committee structure that evolved from the Committee on Commissions which met on March 9, 1972, and from the recommendations of Commissioner Winfred Lee. These propose that the Medical Services Commission include the following committees:

- (a) Fee Survey Committee
- (b) Workmen's Compensation Committee
- (c) Crippled Children Committee
- (d) Professional Liability Committee

CHARLES S. JUDD, JR., M.D.

Commission on Medical Services

Your Reference Committee next considered the report of the Commission on Medical Services. Your Committee recommends approval of the recommendation of (a) and (b) under the recommendation. Your Committee further recommends that (c) Crippled Children under the recommendation be deleted and that the committee be placed under the Commission on Public Health under Children and Youth Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNITY RESEARCH BUREAU

No meetings of the Community Research Bureau were held during the past year.

B. ALLEN RICHARDSON, M.D.

Community Research Bureau

Your Reference Committee next considered the report from the Community Research Bureau. It was noted that this bureau functions as the repository of funds for the

administration of the EMCRO project and other educational funds. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DISASTER

The Disaster Committee did not meet during the past year.

EDMUND C. K. LUM, M.D.

Disaster

Your Reference Committee next considered the report of the Disaster Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FEE SURVEY

The Fee Survey Committee met numerous times during the year, and three times with HMSA representatives to discuss mutual problems associated with the new 1970 RVS. Major problems arise because physicians do not take time to learn how to use the new RVS. Also, there were some omissions and errors that had to be corrected.

The Fee Survey Committee also traveled to the neighbor islands to conduct seminars on use of the new RVS. Use of the 1970 RVS is becoming quite widespread, and many inquiries about it have been received from the mainland.

RECOMMENDATION: That HMA take a firm stand on the use of the 1970 RVS and notify the Department of Social Services that it is completely unacceptable for HMA members to use the 1965 RVS for DSS billings.

BUDGET REQUEST:

Funds for spot surveys	\$1,000.00
Printing Funds	200.00
TOTAL	\$1,200.00

MAURICE W. NICHOLSON, M.D.

Fee Survey

Your Reference Committee next considered the report of the Fee Survey Committee. Since the DSS has stated they are converting to the 1970 RVS and are holding a hearing on May 16 regarding the implementation of the 1970 RVS, your Committee recommends that the last sentence in the second paragraph be deleted. Your Committee further recommends that the recommendation be amended to read as follows: "That HMA take a firm stand on the use of the 1970 RVS by all its members and that the 1970 RVS be used in any negotiation with all third parties."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAMPAC

Purpose of American Medical Political Action Committee: To raise funds through membership to support people into office who are sympathetic towards high standards of medicine, private enterprise and free choice of physicians.

Activities of 1971 and 1972: The membership has been approximately the same as the previous report, about 25% of the physicians. This was a non-election year so

the activity has been quite small. Mr. Thorson attended the AMPAC Workshop in Washington, D.C., in March, 1972. He came back with information, especially the requirements of political action committees and filling out forms to be sent to various government agencies to be used as a cross reference by these agencies as to what contributions candidates have received.

Goals and Recommendations: It is my opinion that considerable can be done with HAMPAC to raise more funds and to have doctors participate more in politics, but as yet a new Board of Directors has not been appointed. I think this is very badly needed, in order to continue the much-needed work in this area.

DON E. POULSON, M.D.

HAMPAC

Your Reference Committee next considered the report from HAMPAC. Your Committee recommends under Goals and Recommendations the adding of the words "a" and "amount" before and after the word "considerable." Your Committee further recommends that the words "very badly needed" be deleted and the word "urgently" be substituted.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. It was moved and seconded to delete the last paragraph of the report. The amendment passed.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

HOSPITAL

The Hospital Committee developed the following goals for this year: (1) Make known that the Hospital Committee exists, (2) Develop HMA inter-relationships with hospitals, (3) Liaison with chiefs-of-staff of Oahu hospitals, (4) Liaison with the University and hospitals, and (5) Liaison with HMA and the Hospital Association of Hawaii.

The first four goals were explored with meetings with the chiefs-of-staff of Kaiser Hospital, St. Francis Hospital, Queen's Hospital, Kuakini Hospital, Children's Hospital, and the Shriner's Hospital. Because negotiations with the University were occurring at the time, the initial meetings were primarily centered around the negotiations that the individual hospital had with the University. It was felt that this interchange of ideas between the chiefs-of-staff was helpful in their individual negotiations.

On March 15, 1972 the first draft of a revision of Public Health Regulations, Chapter 12, relating to Hospitals, was received. A meeting was scheduled for comments, critique, and review of this first draft. The document was to be referred to the Council for further review prior to returning it to the Department of Health.

RECOMMENDATIONS:

- (1) That the Committee continue to be a meeting ground for the chiefs-of-staff of the Oahu hospitals
- (2) That the Committee review subsequent drafts of the revision of Public Health Regulations, Chapter 12, Hospitals.

GORDON LIU, M.D.

Hospital

Your Reference Committee next considered the report of the Hospital Committee. Your Committee recommends approval of recommendations #1 and #2. Your Committee further recommends that the Hospital Committee send a tentative agenda in advance especially to the neighbor island members of this committee when a meeting is scheduled.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGAL COUNSEL

This report covers the calendar year 1971 during which your legal counsel attended the meetings of the House of Delegates and most of the meetings of your Council, and handled administrative calls and matters for the Association as required by your officers.

The subjects on which we conferred included questions on drug abuse, malpractice, insurance, "Death with Dignity," the code of cooperation with media, Publicity Code, EMCRO, RMP and RCUH, physician's assistant legislation, Medical Practice Act and legislation, continued occupancy of Mabel Smyth, The Tumor Registry, a query to the Social Security Administration, Phase II, and miscellaneous other items.

The major service by legal counsel in 1971 related to the appeals to the Circuit Court and the Labor and Industrial Relations Appeal Board relating to Workmen's Compensation fee schedule.

Your legal counsel has no recommendations.

V. THOMAS RICE

Legal Counsel

Your Reference Committee next considered the report of the Legal Counsel. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL CARE PLANS

During the past year no problems, proposals or plans were brought up to the Medical Care Plans Committee for discussion and disposition. This Committee operated with no allocations during the past fiscal year and does not anticipate the need for a budget during 1973.

RECOMMENDATION: The Committee should be phased out or its function amalgamated with the Peer Review Committee.

BENJAMIN C. K. TOM, M.D.

Medical Care Plans

Your Reference Committee next considered the report of the Medical Care Plans Committee. Your Committee recommends that the recommendation be amended to read as follows: "This committee should be amalgamated with the Peer Review Committee." Delete the words "should be phased out."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL EDUCATION

The activities of the Medical Education Committee were concerned in the following areas:

(1) The seminars held at Makaha relative to the Episode of Illness and Ambulatory Care portion of the HMA-Payne Quality of Care Study are basically a program in continuing medical education. The Committee is attempting to assess the efficacy of this method in continuing medical education through feedback processes and review of objective performance data. The Hawaii Experimental Medical Care Review Organization (EMCRO) was initiated by the HMA-Payne study and is picking up

where the Quality of Care Study ends. The objective is to facilitate the continuing review of the quality of health care delivered in the State of Hawaii and quality of medical care within this State. The Hawaii Medical Association Continuing Education Committee will work with the EMCRO project staff to develop programs of continuing education based on review of performance data, assist EMCRO staff in the development and implementation of ambulatory care feedback seminars, develop liaison with HMA Scientific Program Committee to develop a portion of the annual program based on educational needs, and design and issue certificates of recognition for participating hospitals and physicians.

(2) The Medical Education Committee met with the Dean and representatives of the University of Hawaii Medical School to get a status report on the formation and operations of the degree granting Medical School, to discuss the medical school curriculum, and to obtain a progress report of affiliation negotiation between the Medical School and the hospitals.

(3) The Committee heard from a representative of the Kaiser Permanente Hospital and Clinic, Oakland, California, regarding their efforts in public health screening and public education by audio-visual methods.

RECOMMENDATION: That the Medical Education Committee work with the Scientific Program Committee in developing the continuing education programs based on needs reflected by the EMCRO project.

GLENN KOKAME, M.D.

Medical Education

Your Reference Committee next considered the report of the Medical Education Committee. Your Committee recommends approval of the recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEGOTIATING

The Negotiating Committee did not meet during the year.

CHEW MUNG LUM, M.D.

Negotiating

Your Reference Committee next considered the report of the Negotiating Committee. Your Committee recommends that an Ad Hoc Negotiating Committee be formed as the need arises.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PHARMACY

The Pharmacy Committee worked with HMA officers and other committees to develop a voluntary drug abuse program for the HMA membership. The membership was asked to voluntarily restrict the prescribing and dispensing of amphetamines and methamphetamines to only those conditions that indicate a clear medical need. The HMA felt that limiting the legitimate supply of these drugs coming into the State should have the effect of spotlighting the illicit supply and suppliers.

RECOMMENDATION: That HMA members be urged to continue to voluntarily limit their prescription of those drugs in the amphetamine class to specific medical indications.

LAWRENCE Y. W. WONG, M.D.

Pharmacy

Your Reference Committee next considered the report of the Pharmacy Committee. Your Committee recommends approval of the recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PEER REVIEW

This Committee was assigned to the Commission on Medical Services. Its members have not yet been named.

H. TOM THORSON

Peer Review

Your Reference Committee next considered the report of the Peer Review Committee. Your Committee recommends that the words "Medical Services" be deleted and insert the words "Medical Education and Peer Review."

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. A motion was made and seconded to amend the report as follows: That the Peer Review Committee be appointed immediately and draw up a plan for a statewide peer review mechanism and that this plan be distributed to those component societies who have not already established a peer review mechanism. The amendment passed.

A motion was made and seconded to delete the word "immediately" from the amendment and substitute the words "as soon as possible." The amendment passed. There was one dissenting vote.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

PROFESSIONAL LIABILITY INSURANCE

In 1971, the Professional Liability Insurance Committee negotiated with Argonaut Insurance Company to provide professional liability insurance coverage in the State of Hawaii. A satisfactory insurance program was set up with Argonaut.

Argonaut Insurance Company agreed to insure all members of the Hawaii Medical Association along a standard rate schedule involving the five classes of risk. They agreed *not* to rate up anyone who is accepted for insurance under the Medical Association's sponsored program. This means that if a physician or surgeon had a malpractice action lodged against him it would not increase his insurance premium. Every physician accepted into the program would be charged the same premium rate according to his class risk.

Argonaut further agreed not to increase the professional liability insurance premiums for partnerships or professional corporations thus providing a significant savings in premiums to a large number of physicians in the State.

Argonaut further agreed that only 28 percent of the premium dollar would be used for administrative costs. The remaining 72 percent would be placed in a fund to pay off claims. This claim fund would be periodically reviewed, and if experience warranted, a portion of each physician's premium would be returned to him. The plan began in March of 1971 with the first review of claims to be made in 20 months. This review will be made at the end of 1972 and there is a good chance that a premium refund will be made.

The Professional Liability Insurance Committee has assisted several physicians in the community in obtaining professional liability insurance. If a physician or surgeon is refused insurance, he may request that the Professional Liability Insurance Committee investigate the causes for refusal of the carrier to insure him, and if possible, suggest a remedy or compromise so that the physician may obtain liability insurance. There have been six in-

stances where a formal application for help to the Committee has been made over the past year. Five of these have been resolved favorably and one is still under consideration. In numerous other instances the Committee has been able to secure professional liability insurance coverage for members of the Medical Association with only informal discussions with the carrier. To date, no Medical Association member applying for insurance under the Argonaut plan has been denied coverage.

The Professional Liability Insurance Committee working with the Legislative Committee has proposed legislation to ease the malpractice insurance problem in the State. Some of the bills proposed include a shorter statute of limitations in malpractice claims, a bill to provide immunity from malpractice action for physicians and CPR teams and physicians called as consultants in complicated cases which may end in a malpractice suit. The Committee also supported legislation to eliminate legal contingency fees in medical malpractice actions.

The Professional Liability Committee is considering legislation to provide for a medical malpractice commission consisting of lawyers and physicians with a circuit court judge as its chairman. This commission would act with the power of a circuit court reviewing malpractice liability claims both with regard to determining liability and setting judgments. Appeal from this commission would be only to the Supreme Court of the State. This concept should be explored further in the coming year.

ALAN PAVEL, M.D.

Professional Liability Insurance

Your Reference Committee next considered the report of the Professional Liability Insurance Committee. Your Committee recommends that in the 5th paragraph, last sentence, substitute the word "one" for the word "no" before Medical Association member, as there is now one member who has been denied coverage.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC RESEARCH

This Committee was formerly called the AMA-ERF Committee. For the year 1971, a check from the AMA-ERF representing contributions earmarked by donors for the University of Hawaii School of Medicine will be presented to the University of Hawaii in the amount of \$6,180.11 at the HMA's Annual Banquet on May 12, 1972.

BUENAVENTURA REALICA, M.D.

Scientific Research

Your Reference Committee next considered the report of the Scientific Research Committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WORKMEN'S COMPENSATION

As all physicians should be aware, the new Regulation 31 of the Workmen's Compensation Law went into effect last August. This new Regulation involves two major changes: (1) that the fees for Workmen's Compensation cases were adjusted upward, approximately equivalent to our 1965 RVS at 6.0; and (2) that "specialists," defined by Workmen's Compensation to be those physicians and surgeons that are certified as a diplomate by their respective specialty boards, are allowed a 25% differential

in their fees. Your Committee has opposed these changes in line with the principle set down by your Committee last year that the prevailing fee should be paid on the usual, customary and reasonable concept, and in line with your Committee's support of the AMA definition of a specialist as one who limits his practice to one field of medicine or surgery. These concepts of usual; customary and reasonable and of specialist definition were presented at the public hearings in December, 1970. Thus, the HMA had decided to join with the orthopedic-neurosurgeon group in filing suit against Workmen's Compensation asking that the Director of Labor be directed to re-issue Regulation 31 based on a fair interpretation of the testimony presented at the public hearings. A complete memorandum of the suit will be filed in early June with the suit to be heard in court sometime in July, 1972. The HMA House of Delegates, in 1971, authorized an expenditure of up to \$5,000 for legal fees. This amount is just about spent. It is estimated by our legal counsel that an additional \$20,000 is necessary to complete the follow-up in court.

In an effort to resolve the difficulties over Regulation 31, a bill, S.B. No. 1950-72, was introduced into this year's Legislature by Senator Nadao Yoshinaga in which the Director of Labor was given a choice of one of two methods in determining compensation for physician services under Workmen's Compensation. These two methods, basically, were (1) adoption of the most current RVS of the HMA with utilization of the Consumer Price Index of the U. S. Bureau of Labor Statistics as adjusted for Hawaii in determining the appropriate conversion factor for any given year; (2) use of the concept of usual, customary, and reasonable charges. This bill, during public hearings, was opposed by the Director of Labor, the Board of Underwriters of Hawaii, and the Inter-Industry Workmen's Compensation Study Committee. This bill did not succeed in passing.

Your Committee has met with our legal counsel and individually with the Director of Labor in an effort to resolve our difficulties with Regulation 31. Presently, Regulation 31 is still in effect and our joint suit against Workmen's Compensation is still in the mill. Your Committee, at its last meeting, considered continuation of our court action. While there was no definite action to proceed, neither was there any action to drop the suit. If your Committee is to proceed any further, it will require authorization for an expenditure of legal fees.

BUDGET REQUEST:

Legal Fees \$20,000.00

RECOMMENDATIONS:

- (1) That the HMA Legislative Committee be kept abreast of any developments in the Workmen's Compensation situation and that legislation similar to S.B. No. 1950-72 be pursued in the next legislative session.
- (2) That this Committee work with the Dept. of Labor and the insurance companies in a cooperative effort to resolve mutual problems.

ALBERT C. K. CHUN-HOON, M.D.

Workmen's Compensation

Your Reference Committee next considered the report of the Workmen's Compensation Committee. Considerable discussion was had on whether we should pursue our suit against Workmen's Compensation through legal action or legislative action. The Legislative Commissioner was present at the hearing and it was his opinion that we should pursue this problem through both legislative and court action. Your Committee recommends approval of the Budget Request and further recommends approval of Recommendations 1 and 2.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. A motion

was made and seconded to amend the report by adding Recommendation No. 3 to read: That the suit against the Department of Labor be continued to its conclusion at the discretion of the Council. The amendment passed.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

RESOLUTION NO. 3 AS ADOPTED

Re: Medical Care

WHEREAS, controlling medical costs requires the co-operation of the insurers and providers of medical care, now therefore be it

Resolved, that the officers, staff and committees of the Hawaii Medical Association be encouraged to work with all insurance carriers including HMSA in solving the problems of the delivery and financing of medical care, and be it further

Resolved, that all medical directors, physician directors, and physician members of review committees of insurance carriers including HMSA be invited to meet with the officers and committees of HMA to share information and concerns regarding the delivery and financing of medical care.

Submitted by JOHN J. LOWREY, M.D.

Resolution No. 3

This resolution relates to Medical Care. A full and complete discussion was held. Your Committee recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 3 be adopted. It was adopted.

RESOLUTION NO. 8 AS ADOPTED

Re: Medcredit

WHEREAS, there is increasing concern in the Congress and by the public about the enactment of any program for national health insurance, and

WHEREAS, many proposals for national health insurance have been introduced in the Congress, and

WHEREAS, the medical profession is concerned for the continued development of quality medical care and for the availability to all persons of insurance protection providing comprehensive health care benefits, and

WHEREAS, the medical profession believes that any national program should build upon the strengths of our present system of health care delivery, without detrimental and radical restructuring, but offering a variety of pluralistic means of health care delivery, and

WHEREAS, one bill introduced in the Congress and known as Medcredit (S. 987 and H.R. 4960), formulated by the American Medical Association, embodies beneficial and essential principles which should be embraced within a program for national health insurance, therefore be it

Resolved, that the Hawaii Medical Association does hereby endorse the Medcredit program and does further recommend that the following basic Medcredit concepts be considered in any national health insurance:

That individuals should have available to them insurance protection, underwritten by risk bearing insurance companies, providing comprehensive basic health protection and also including protection against the catastrophic costs of illness;

That pluralistic means of health care delivery should be afforded, with the individual having the freedom of receiving care from qualified providers of his choice;

That any federal funding should be provided through general revenues, with government subsidy or assistance related to the individual's ability to pay;

That cost sharing by the beneficiary, while fostering individual responsibility, should be reasonable and not act to prevent access to health care;

That insurance policies or plans be qualified by appropriate governmental regulatory bodies; and be it further

Resolved, that this Medcredit endorsement and support for basic Medcredit principles be communicated to appropriate members of the Congress including members of the House Ways and Means Committee and the Senate Committee on Finance, as well as to the Board of Trustees of the American Medical Association.

Submitted by GEORGE H. MILLS, M.D.

Resolution No. 8

This resolution relates to Medcredit. A full and complete discussion was held. Your Committee recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 8 be adopted. It was adopted.

RESOLUTION NO. 11 AS ADOPTED

Re: DSSH

WHEREAS, the providers of medical services to the clients of DSSH, both physicians and hospitals are required by law to offer their services at discounted rates, now therefore be it

Resolved, that HMA representatives and representatives of other providers of such discounted services in the State be consulted by the Regulatory Boards and Agencies concerned with such services, in their deliberations.

Submitted by J. I. F. REPPUN, M.D.

ACTION:

The Chairman moved adoption of the report as a whole as amended. It was adopted.

Resolution No. 11

The resolution relates to DSSH. A full and complete discussion was held on the resolution as presented. Your Committee recommends that the 2nd WHEREAS be deleted; that the 3rd WHEREAS be deleted; that the 1st RESOLVED be deleted; and further recommends that last RESOLVED be amended to read as follows: "Be it further resolved, that HMA representatives and representatives of other providers of such discounted services in the State be consulted by the Regulatory Boards and Agencies concerned with such services in their deliberations." Your Committee recommends approval of this resolution as amended.

ACTION:

The Chairman recommended that Resolution No. 11 be adopted as amended. There were objections. It was moved and seconded to allow Dr. Reppun to address the House on this subject. The motion passed.

A motion was made and seconded to delete the recommendations of the Reference Committee and that the resolution be voted on as originally presented. The motion was defeated.

The Chairman recommended adoption of the Resolution as amended. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and guests and received

testimony on the various reports and resolution submitted to the Committee for consideration and recommendation. Having heard the discussions of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

ARRANGEMENTS

This Committee again worked with Mr. Harold Brown of the Conference Center of the University of Hawaii Continuing Education and Community Affairs in coordinating the activities of the Annual Meeting. Early in the year, the entire Pacific Ballroom of the Ilikai was established as the locale for all scientific meetings, exhibits, House of Delegates meetings, and the annual banquet. Forty-nine booths will be set up for exhibits by the pharmaceutical companies, health agencies, and other organizations.

Subcommittee chairmen made early plans for sports and social activities. Medical Service Representatives were invited to Committee meetings to serve as consultants. Pharmaceutical exhibitors were invited to participate in all social and sports activities except fishing and skin diving due to the limited number of space available for participants.

Tennis (Dr. Yutaka Yoshida, chairman): Ala Moana Courts will be used for the tennis tournament on April 23, 29 and 30.

Golf (Dr. Donald Maruyama): The golf tournament will be held at the Francis Brown Golf Course on Friday, May 12. Since two trophies were retired in 1971, two more will be put up. They are the John Felix Memorial Trophy for low gross and the Robert Miyamoto Memorial Trophy for low net. Arrangements for funding by donations and purchasing these trophies are being handled by Dr. D. Maruyama and Dr. T. Fujii.

Bow and Arrow Hunting (Dr. William Davis, chairman): This tournament was initiated last year and, although attendance was low, it is hoped that more participants will be attracted to this event this year. It is scheduled for May 5-7 on the Big Island.

Fishing (Dr. Andrew Morgan, chairman): Three private boats will be used for the fishing tournament on May 7. Charter boats will be used if necessary.

Skin Diving (Dr. Henry Yokoyama, chairman): This tournament was initiated this year with enthusiasm and will be limited to a select few due to limited space at least for this year. A private plane will take participants to Kalaupapa, Molokai, with permission received from the Department of Health. Dates for this tournament are April 22-23.

Sportsmen's Night (Dr. Coolidge Wakai, chairman): This year the popular Sportsmen's Night Party will be held on a Saturday (May 13) instead of on a Friday as in previous years. It will be held at the Natsunoya Tea House where all sports tournament awards will be presented.

Annual Banquet (Dr. Robert Ballard and Dr. Herbert Pang, co-chairmen): The Pacific Ballroom is the locale for the annual banquet on Friday night, May 12. A seven-course Chinese dinner is planned, followed by entertainment by the Aiea Singing Swingers. The A. H. Robins Award and journalism awards for educational and professional medical writing will be presented at this time.

Woman's Auxiliary: The Woman's Auxiliary will hold their annual meeting and luncheon at the Waikiki Sheraton on Friday, May 12. They will be serving donuts during the early morning intermissions of the scientific meetings, and will also assist the staff in registration and telephone answering service.

Although tentative reservations for locale and date for future meetings were made several years ago, the Association's annual meeting has outgrown the facilities of most of the hotels. In addition, there are conflicting dates with other organizations' meetings. For these reasons the Committee voted to have Mr. Brown make a study and

to make tentative reservations where it is most suitable.

The Committee also voted to consider scheduling an interim clinical meeting in "mid-year" and to consider a neighbor island as the locale.

RECOMMENDATIONS:

- (1) That the Committee continue to utilize the services of the Conference Center at the University of Hawaii
- (2) That Mr. Brown be allowed to make tentative arrangements for future meetings up to 1977
- (3) That specific guidelines be established for accepting exhibits at the annual meeting
- (4) That next year's committee start its planning early in order to expedite the numerous activities of the annual meeting.

R. VARIAN SLOAN, M.D.

Arrangements

Your Reference Committee considered the report of the Arrangements Committee. A full and complete discussion of the project was held. Your Committee recommends that Recommendation No. 3 be changed to read "That specific guidelines for accepting exhibits be established by the Arrangements Committee with the approval of the Council for the annual meeting." Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections.

A motion was made and seconded that the Arrangements Committee consider having the annual banquet cosponsored by the County Woman's Auxiliary AMA-ERF Committee. The motion was defeated. The President ruled that this motion was out of order since it had reference to another report and not of that being discussed.

The Chairman moved adoption of this portion of the report. It was adopted.

ASSOCIATION OF PROFESSIONS

This Committee has been more active than in any past year. The Chairman has met with representatives of nine other State professional organizations three times (another is scheduled in April), and with another member, met with subcommittees working on draft statements of objectives, bylaws, and articles of association for a proposed Hawaii Association of the Professions. At a meeting of the full Committee approval in principle of tentative thinking about such an organization was reached and Drs. DeJesus and Schnack named to represent HMA in further negotiations on the project. It is anticipated that proposals on the above-mentioned documents will be ready for submittance to the House of Delegates at the Annual Meeting with the recommendation that HMA become a charter State Organization Member.

At the moment it is anticipated that this will entail original dues of \$50.00/year, the first payable before the next fiscal year. Dues payable during fiscal 1973 may well be \$100.00.

Presumably, once the Hawaii Association of the Professions has been organized and incorporated in the State of Hawaii and HMA has become an organization member, the purpose of this Committee will have been discharged and it should be terminated. However, a suggestion has been made to HCMS Board of Governors that its Inter-Professional Relations Committee should be made broader in scope (it now functions almost purely in medical-legal areas), probably duplicated for each profession with whom physicians could have mutual concerns, and each of these transferred to HMA where they could be subsumed under this reporting Committee. As all the professions in Hawaii, other than

the medical, are organized solely on a state-wide basis, the proper locus of such committees in the medical profession, at this time, is at the state level. To accommodate such a restructuring, the objectives of the Association of the Professions Committee should be broadened and redefined next year.

RECOMMENDATIONS:

- (1) That HMA study the proposed Hawaii Association of the Professions and become a State Organization Member
- (2) That the objectives of the HMA Association of the Professions be restated during the next year so that it would take over the present HCMS Inter-Professional Relations Committee and other similar committees as sub-committees (or create them).

BUDGET REQUEST:

Dues to Hawaii Association of the Professions	\$100.00
Promotion for HMA members to join said Association	100.00
TOTAL	\$200.00

GEORGE F. SCHNACK, M.D.

Association of Professions

Your Reference Committee next considered the report of the Association of Professions. A full and complete discussion of the subject was held. Your Committee notes that in Paragraph 2 Line 2 "original dues of \$50.00/year" should be changed to read "original dues of \$100.00/year." Your Committee recommends that Recommendation No. 1 be changed to read "That HMA study the proposed Hawaii Association of the Professions and consider becoming a State Organization Member." Your Committee further recommends that Recommendation No. 2 be deleted. The budget request is included in the Treasurer's Report. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AWARDS AND SPECIAL PROJECTS

The Committee had one meeting this year at which time nominations for the Robins Award were made, and awards for the Hawaiian Science Fair, and HMA contribution to the Hawaii Academy of Science were discussed.

Robins Award: Nominations for the Robins Award for the "Physician of the Year for Community Service" were received from the HMA membership. The Committee selected the recipient whose name will be revealed at the Annual Banquet on Friday, May 12, 1972.

Hawaiian Science and Engineering Fair: This year the Committee decided to award certificates instead of small monetary gifts to the winners in the medical science division of the Hawaiian Science Fair. It was felt that this gesture would be more meaningful and lasting. Dr. William Sage and Dr. Bunzo Nakagawa were selected from the Committee to represent the Association in the presentation of awards on April 7th at the Honolulu International Center.

Inter-Society Science Education Council (ISSEC): The Committee voted to contribute \$100 to the ISSEC of the Hawaiian Academy of Science. This contribution goes toward funding the Hawaiian Science Fair and other educational activities of the Academy in its development of scientific talent in Hawaii's youth.

The Chairman wishes to thank the members of the Committee for their excellent cooperation in carrying out the Committee's responsibilities.

BUDGET REQUEST:

Prizes (certificates, printing, frames)....	\$100.00
Contribution to ISSEC	100.00
TOTAL REQUEST	\$200.00

K. S. TOM, M.D.

Awards and Special Projects

Your Reference Committee considered the report of the Awards and Special Projects Committee. A full and complete discussion of the subject was held. The Treasurer's Report includes the budget request of this committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CAREERS

The Careers Committee has met a number of times and decided that we would not have a Doctors Careers Day in 1972. We are planning to take part in the Health Careers Council which, in reality, the HMA is sponsoring for 1972. There will be a Health Careers Day held at the HIC on October 18, 1972 to which high school students will be invited to participate.

The Woman's Auxiliary will handle the publicity for this and also will be contacting high school principals and counselors to explain the coming program.

BUDGET REQUEST:

HMA share of neighbor island student's travel	\$250.00
HMA share of Health Careers Day	250.00
TOTAL	\$500.00

H. WM. GOEBERT, JR., M.D.

Careers

Your Reference Committee considered the report of the Careers Committee. A full and complete discussion of the subject was held. The budget request is included in the Treasurer's Report. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON INTERNAL AFFAIRS

The Arrangements Committee completed most of the preliminary plans for the annual meeting early and encountered no major difficulty. Two reasons for the ease with which the committee operated this year are that the Ilikai was again the locale for the meeting, and that Mr. Harold Brown of the University of Hawaii's Conference Center was again contracted to coordinate activities.

Due to the increasing cost of our annual meetings it was felt by the Arrangements Committee that by having the annual banquet on Friday night it would thus save the Association \$750 since the Sportsmen's Night Party is held at a location away from the convention site. In addition, the Committee felt that having the banquet one day earlier may entice neighbor island physicians to attend this significant annual social event of our Association.

This year we received two requests for wet clinics; namely United Medical Laboratories and Ayerst Laboratories. Unfortunately the Committee was not aware of the policies of the AMA and the State health regula-

tions: therefore it was felt that it would be best to decline all wet clinics this year but to study this matter and set up guidelines for future requests.

By October, 1971, the Scientific Program Committee completed an outline for the 1972 program with guest lecturers confirmed for an interesting session. Host physicians, presiding officers, and moderators were appointed. The structured plans for preparation of the scientific program were again utilized.

The House of Delegates will meet on Tuesday and Thursday afternoons to enable the secretaries to complete the Reference Committee reports on Wednesday.

The Awards and Special Projects Committee met once and selected the winner of the A. H. Robins Award from nominations from the membership. The Committee also voted to contribute \$100 to the Academy of Sciences to continue their work in scientific education.

The Bylaws and Parliamentary Committee did not formally meet this year, but due to the study conducted by the "Blue Ribbon Committee" headed by Dr. George Mills it is anticipated that this Committee will play a major role in rewriting the Bylaws in the reorganization of the Association.

The chairman of the Ad Hoc Committee to Coordinate the AMA Clinical Session presented a report of the planning currently underway for the 1975 AMA Clinical Convention to be held in Honolulu from November 30 to December 5, 1975.

RECOMMENDATIONS:

- (1) To continue to invite the pharmaceutical representatives to participate in as many of our activities as possible to maintain our friendly cooperative relationship
- (2) To continue to have the sporting events that have good participation with evaluation of these events by the participants as to whether they would like to have them renewed at the next annual meeting
- (3) Consider holding the annual banquet again on Friday night and Sportsmen's Night Party on Saturday night if this change proves successful and satisfactory to all concerned; ie. to physicians, staff and displayers
- (4) That wet clinics be permitted if these can be held in compliance with State health regulations and policies of the medical association
- (5) That we continue the same format for the Awards and Special Projects Committee
- (6) That the Arrangements Committee, Scientific Program Committee, and the Ad Hoc Committee to Coordinate the AMA Clinical Session be combined to be called Conventions Committee, thus all matters relating to meetings and conventions involving the HMA will be handled by this Committee.

COOLIDGE S. WAKAI, M.D.

Commission on Internal Affairs

Your Reference Committee considered the report of the Commission on Internal Affairs. After a full and complete discussion, your Committee recommends approval of the report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON INTERPROFESSIONAL AND PUBLIC RELATIONS

This Commission consists of the following 13 committees: Association of Professions, Careers, Disaster, Filipino Speakers Bureau, Health Manpower, Japanese Speakers Bureau, Medicine and Religion, News Media, Operation Pacific, Public Relations, Quackery, TV-Radio, and Woman's Auxiliary.

The various committee reports cover thoroughly the major activities and recommendations of each committee. The Commissioner wishes to commend the chairmen and members of these committees for their dedicated, conscientious and innovative efforts towards fulfilling their goals and objectives for the year. He also wishes to commend the secretarial staff attached to the committees for their prompt support and efficient back-up work. It was indeed a distinct privilege and honor to have worked with these men and women.

RECOMMENDATIONS:

- (1) That the HMA accept, adopt and implement the proposed Advisory Board of Consumers or Community Advisory Board to the HMA Council as directed by the previous House of Delegates.
- (2) That HMA approve and institute the proposed changes in the Commission structure and committee make-up of these Commissions as proposed by the Committee on Commissions appointed by the HMA President
- (3) That HMA publicize outstanding public relations and image-building achievements that have been made by the HMA and the AMA; outstanding achievements and activities of HMA members; problems related to legislation that are current, occurring both locally and nationally
- (4) That HMA direct the committees to send representatives to the Public Relations Committee to develop an overall strategy for public relations and work from an overall program
- (5) That HMA form an effective medical speaker and writer's bureau as a means of strengthening community and public relations. Such a program could be related to legislative, community health education, community health problems and particular accomplishments of the HMA in the community.

CESAR B. DEJESUS, M.D.

Commission on Public and Interprofessional Relations

Your Reference Committee considered the report of the Commission on Public and Interprofessional Relations. A full and complete discussion on the report was held. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. A motion was made and seconded to defer action on Recommendation No. 1 and that the Proposal for Advisory Board of Consumers be referred to the Council for further study. The motion passed. There was one opposing vote.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

FILIPINO SPEAKERS BUREAU

The Filipino Speakers Bureau has initiated a monthly Filipino medical television program on Channel 13. The program is broadcast on the last Saturday of each month at 4:00 P.M.

Our thanks to Mr. Tony Cacatian and Mr. Pete Ramos for all their assistance and encouragement.

BUDGET REQUEST:

Appreciation awards for Mr. Cacatian and Mr. Ramos	\$ 20.00
Miscellaneous—education functions	80.00
TOTAL	\$100.00

QUINTIN L. UY, M.D.

Filipino Speakers Bureau

Your Reference Committee considered the report of the Filipino Speakers Bureau. A full and complete discussion of the subject was held. The budget request is reflected in the Treasurer's Report. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

The JOURNAL has continued to be published every two months during the past year. The last six issues have comprised 520 pages. Because of our almost year-long backlog, a record 30 articles, occupying 130 pages, have been published. There have been 13 editorials, covering 12 pages. No change has been made in the feature articles, and the Hawaii Pharmacists' Bulletin has been continued.

Robert Moser, M.D., was added to the masthead as contributing editor in the March-April issue of 1971. In the September-October issue, Paul Steward replaced Marilyn Wall, who had to return to the mainland, as assistant editor. In the November-December issue his title was changed to the more accurately descriptive one of executive editor, and Doris Jasinski, M.D., returned to the staff as assistant editor with the primary responsibility of manuscript editing, taking a major burden from the shoulders of your editor.

Mr. Steward has proved to be an excellent choice for the major responsibility formerly borne by Lee McCaslin; he has full charge of advertising, and does all the make-ready work and dummieing to translate the type-written material into printed, bound pages. He has already achieved a significant upswing in local advertising, to our financial benefit. Mainland advertising is holding its own and should do even better when we are able to complete our projected changeover from letterpress printing back to offset again. This is a technical problem which Mr. Steward is fully competent to plan and put into effect.

The prospects for higher income for the JOURNAL seem good just now. Our most pressing problem is the unsettled tenure of Mr. Steward, but he has assured me he will not leave us without a replacement, at any rate.

RECOMMENDATION: That the continued publication of the HAWAII MEDICAL JOURNAL be authorized on the same basis as in the past.

HARRY L. ARNOLD, JR., *Editor*

Hawaii Medical Journal Editor

Your Reference Committee considered the report of the HAWAII MEDICAL JOURNAL Editor. A full and complete discussion was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEALTH MANPOWER

The Health Manpower Committee held six meetings during the preceding year, in addition to three joint meetings with similar groups in the community. A major accomplishment has been the defining of identities and major roles of the various groups in the State interested in health manpower: Comprehensive Health Planning (PL 89-749) with its planning roles; Regional Medical Programs (PL 89-239) with their newly defined involvement with accessibility, delivery of care and its manpower implications; the School of Medicine with their recent new funding source for training of Allied Health Personnel (AHP) through the Comprehensive Health

Manpower Training Act of 1971 (PL 92-157); certain community clinically-based groups working partially through the Hawaii Association of Medical Clinics; and the HMA.

Noteworthy national trends during the year included the development of AHP program accreditation mechanisms through the AMA; DHEW support for the moratorium on "enactment of legislation establishing new categories of health personnel with statutorily-defined scopes of functions; DHEW support for development of meaningful equivalency and proficiency examinations, as well as support for recertifying in some form to assure maintenance of competence; vigorous action by the AMA toward a system of national certification for AHP; and activity on the national as well as state level towards formation of a joint practice commission for the definition of roles of physicians, nurses and subsequently, other classes of health manpower.

Locally, the Committee considered legislation relating to physician's assistants (HB 1632) and recommended against its passage; recommended support for the concept of AHP certification rather than licensure as the mechanism for recognizing competence; continued the canvassing of local physicians concerning their willingness to use a physician's assistant; agreed to support broad interpretations of the existent medical practice act, and/or amend it, as the means to facilitate use of physician's assistants; cooperated with CHP in gathering a substantive survey of health manpower within the State; met with Dr. Richard Smith (McDex), and DHEW accreditation/certification/licensure experts to develop approaches to our State health manpower problems; discussed the problems of foreign medical graduates unable to pass the ECFMG examination; the residency requirement for physicians; and touched on the issues of relicensure and recertification for physicians.

RECOMMENDATIONS:

- (1) HMA support the continued moratorium on licensing of new categories of health manpower personnel
- (2) HMA support the concepts of national accreditation of AHP educational programs by the AMA Council of Medical Education, and national certification of AHP by the mechanisms being developed by the AMA
- (3) HMA support the rapid development of meaningful equivalency and proficiency examinations for health manpower fields
- (4) HMA support the concept that mechanisms should be developed to assure the maintenance of competence of physicians and other health workers
- (5) HMA participate vigorously with nurses in a State joint practice committee
- (6) HMA support the present (1968) amendment to the existent medical practice act as the means of facilitating utilization of physician's assistants in Hawaii
- (7) HMA support the School of Medicine in its efforts to establish a training program for physician's assistants.

BUDGET REQUEST:

Travel funds for AMA meetings on
Health Manpower \$550.00

H. H. CHUN, M.D.

Health Manpower

Your Reference Committee next considered the report of the Health Manpower Committee. A full and complete discussion on the subject was held. Your Committee recommends that Resolution Nos. 1, 2, 3, 4, 5 and 6 be approved. Your Committee further recommends that Recommendation No. 7 be changed to read "That the HMA, through its Health Manpower Committee, work

with the School of Medicine in its efforts to establish an *appropriate* training program for *allied health personnel*." The Treasurer's Report includes this committee's budget request. Your Committee recommends approval of the report as amended.

Mr. President, I move the adoption of this portion of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

JAPANESE SPEAKERS BUREAU

The Japanese Speakers Bureau continued its KOHO radio program (Monday evenings) and KIKU-TV program (bi-monthly on Thursday evenings). These programs continue to enjoy high poll ratings.

The radio program is 45 minutes long and usually begins with a brief talk on a particular clinical symptom, or disease, followed by direct call-in telephone questions. The half-hour TV program, originally patterned after the radio program, has been changed so that the speaker spends the entire time for his talk with visual aids. The change was aimed at eliminating the phoned-in questions which were time consuming and impractical. Some speakers included non-Japanese-speaking HMA members in panel discussions. Among those HMA members who participated were Drs. C. DeJesus and Goshi discussing Dysuria, Drs. G. Morimoto and Akagi discussing Osteoarthritis, Dr. M. Kaneshiro in a program on CBC with Dr. Goshi and Dr. F. Nakamura who participated in a program on Congenital Heart Disease with Dr. Kawasugi.

With the limited number of members on the Japanese Speakers Bureau, we are aware that many specialty fields are not being covered. Specialists, other than committee members, will be invited to participate in future programs.

Whereas KOHO Radio has been very cooperative in producing our program, there have been difficulties with KIKU-TV and programs have been frequently postponed or cancelled without notification. The Bureau will write to KIKU-TV asking their cooperation in correcting some of the problems.

HIDEO NAMIKI, M.D.

Japanese Speakers Bureau

Your Reference Committee next considered the report of the Japanese Speakers Bureau. A full and complete discussion of the subject was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICINE AND RELIGION

The Medicine and Religion Committee continued its monthly meetings with clergy and physicians. Work on the pamphlet "In Case of Serious Illness" continued. Your chairman attended an AMA regional meeting on medicine and religion in Salt Lake City in February, 1972. An evening meeting on pornography was attended by approximately 80 persons.

BUDGET REQUEST:

Printing of pamphlet \$300.00

FRANCIS H. SOON, M.D.

Medicine and Religion

Your Reference Committee considered the report of the Medicine and Religion Committee. A full and complete discussion on the subject was held. The budget request is included in the report of the Treasurer. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

OPERATION PACIFIC

The Operation Pacific Committee again provided a vehicle by which physicians of the Pacific Basin, particularly Oceania, could contact and exchange ideas with Hawaii's physicians.

This year, members of HMA were present at the Sixth Annual Meeting of the Micronesian Medical Association in the Trust Territories. HMA members also played host to physicians from Ponape, Palau, Truk, Yap, Saipan, and Majuro.

It is the hope of the Committee that such contacts can be expanded in the future.

GEORGE SUZUKI, M.D.

Operation Pacific

Your Reference Committee then considered the report of the Operation Pacific Committee. A full and complete discussion on the subject was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT, WOMAN'S AUXILIARY

Powerful forces of the changing times and their attendant effects made their influence felt on the activities of the Woman's Auxiliary in their untiring and devoted efforts to achieve their goals of assisting the Hawaii Medical Association in its program for the advancement of medicine and public health. An awareness of the need to examine our organization and ascertain its adequacy in meeting the demands of the times was met through a nationally developed program, "Seizing the Times." This program helped us evaluate the roles of board members, committee chairmen, the membership, and the interacting forces among them. We became aware of the importance of having the proper climate within the organization. A climate that would be more conducive to member input, resulting in greater auxiliary output, to community-minded and service-oriented programs and projects.

To remain viable and effective as an organization in the face of these changes, we also restructured our committees for greater flexibility and to enable the focusing of our energies and efforts on meaningful activities attuned to changing needs. The format of our mid-year Conference was changed from a report type meeting to a working meeting, where every member was involved in discussion groups and participated in the program. The response was most favorable. Neighbor island representatives felt the infectious enthusiasm of state auxiliary members.

A real effort was made to develop rapport, and a sense of unity of purpose, among the component county auxiliaries. To this end, we have attempted to provide the means for neighbor island auxiliary participation on state level deliberations. We are pleased that results of setting "our house in order" have been most gratifying. We are heartened by the resurgence of enthusiasm for auxiliary activities by the Hawaii County Auxiliary which rejoined as a component auxiliary just two years ago.

Our committees carried out their activities most effectively as follows:

AMA-ERF: The AMA-ERF Committee has enjoyed another auspicious year under the able leadership of Mrs. Edward Kagihara and her county counterparts. To date, Hawaii is credited with raising over \$8,000.00 out of a

total of \$550,000.00 nationwide. Honolulu County will be sponsoring its annual fund-raising dinner and silent auction, "Hand in Hand," on April 15, 1972. All indications point to another successful benefit. Last year's benefit, "Kalabash," netted a total of \$6,732.95 for AMA-ERF. At the annual Christmas luncheon, AMA-ERF had a boutique that featured Christmas holly, flown in from the Brownell Farms, owned by the father of Patty Lee, President of the National Auxiliary, poinsettia, plants, baked goods, dried floral arrangements, coconut Christmas angels and an honest-to-goodness phantom bake sale. A fashion show by Dano completed a most enjoyable and festive luncheon. Funds for AMA-ERF were also raised through the selling of choice Christmas cards, note cards, watches, jewelry and through direct contributions. Another promising fund-raising project is the Auxiliary Cookbook of choice and favored recipes which hopefully will be completed in another year or two.

Bylaws: The Bylaws Committee chaired by Mrs. R. Frederick Shepard wrote changes in the bylaws to allow for greater flexibility of committees particularly in the area of community health education and volunteer health services, and also to bring committee structure more into line with changes on the national level.

Children & Youth: The Children & Youth Committee headed by Mrs. Garton E. Wall reported that many doctors' wives are working individually as volunteers on projects such as "The Place," a meeting place where teenagers can go and share their problems with professionals and volunteers; "Hale Kipa," a shelter for runaways, and "Habilitat," halfway house for drug addicts. The Committee displayed an exhibit of literatures at the State Conference for county representatives. The chairman attended a seminar on the *Alienation of Youth*.

Community Service: Auxiliary members under the effervescent leadership of Mrs. William F. Moore helped in driving the American Cancer Cruiser, a van equipped with automatic slides, panel posters and pamphlets. The van was driven to schools and shopping centers throughout the year. Members also helped to man an exhibit for the American Cancer Society at the Nurses Convention and will help to man the Cancer Display in April at the Ala Moana Shopping Center where cancer information will be distributed. They also performed a much-appreciated service in manning the Diabetic Detection Booths last November at various shopping centers. Other recipients of auxiliary help included the Blood Bank and the Rubella Immunization program. The auxiliary continues to maintain gift subscriptions of *Today's Health* at numerous schools and to assist the school health coordinators in the dissemination of venereal disease and drug abuse information. Ross Laboratories has contributed an hour long film for use in high schools and Drs. Donald Char and Ralph Hale have volunteered to present talks to interested schools.

After a year of dedicated collecting and relentless counting of literally hundreds of thousands of Betty Crocker coupons, the Honolulu County auxiliary proudly announced that they had at last reached their goal. They were able to obtain a cardiac arrhythmia simulator with mannequin and oscilloscope for the University of Hawaii Medical School. The project elicited much in the way of good public relations with the community and excellent publicity for the auxiliary. The public enjoyed and relished the opportunity of assisting in this worthwhile project.

Health Careers: Members of the Health Careers Committee headed by Mrs. Francis H. Soon attended monthly meetings of the Health Careers Council spearheaded by Dr. Wililam Goebert of the Hawaii Medical Association. The Health Careers Council is made up of twenty professional organizations which sponsor the Health Careers Day. Plans are now being formulated for the third annual Health Careers Day scheduled for October 18, 1972. Auxiliary members will be visiting high schools and intermediate school principals, counselors and students. They hope to help publicize and to sell the administrators on the benefits to be gained by allowing interested

students to attend the Health Careers Day. Committee members also visited school libraries to make sure literature on health careers were available for students and health career posters were on hand for display in the libraries. Members also helped to man a Health Careers booth at a recent school counselor's workshop.

In Memoriam: The In Memoriam Committee chaired by Mrs. Rodney T. West has done another immense and creditable job of compiling nine new biographies and revising twelve existing biographies to include new materials. Also twelve new photographs were added to the files. There are now a total of 472 biographies and 279 photographs on file. As indicated by the HMA Advisory Committee this represents a much appreciated aspect of our auxiliary program. Another source of appreciation came to light in the form of a letter from Alabama inquiring about a physician who had practiced here in 1895. No records were on file, but a search through the medical library produced the *In Memoriam* biography. The physician's daughter turned out to be Mrs. Alfred Magoon.

International Health Activities: The auxiliary outreach extended beyond the shores of our community to help such distant places as India and Saigon through the program of the International Health Activities. Chaired by Mrs. Raymond Fujikami, the Committee sent thousands of pounds of drugs, vitamins and medical equipments by every and any means to India, the Tien Medical Center in Taiwan, the Saigon Seventh Day Adventist Hospital and to Kokua Samoa. Over 3,000 pounds of instruments, books, equipments and drugs are now ready for shipment awaiting the first available carrier.

Legislation: Co-chaired by Mrs. George Mills and Mrs. Ralph Hale, the Legislative Committee conducted a workshop at a recent State Conference. AMA's Medieredit slide presentation was shown and followed by an active discussion session. The following pamphlets were also disseminated: (1) Current National Health Insurance Proposals, (2) Where Do We Stand? and (3) Medical and Health Care for All. The Committee would like more directions from the HMA Legislation Committee as to ways in which they might be helpful. There is also a greater need to build a more positive interest among members in medical legislation.

Membership: The Membership Committee chaired by Mrs. Unoji Goto noted that although the Hawaii auxiliaries have 100% membership, we must strive to activate this membership. Various recommendations were suggested to expedite and implement this goal. One very good means is to have a program with wide appeal such as the program arranged by the Honolulu County auxiliary featuring Sammy Amalu and the Kawaiahao Church Mother's Choir. This meeting brought out over 200 members and guests. The Hawaii auxiliaries have a total of 836 active members and 25 inactive members.

Mental Health: Chaired by Mrs. Norman Goldstein, mental health activities and programs have had statewide interests. Both Hawaii and Maui County auxiliaries have chosen work with the mentally retarded centers as their service projects. Auxilians on Hawaii will work at the Hilo Training and Day Activity Center, Honokaa Brantley Center and the Kona Center. The Maui auxilians will work with the Wailuku Mentally Retarded Day Activity Center. The Hawaii County auxiliary have additionally demonstrated real enthusiasm for their project by sponsoring a letter writing campaign to state legislators to: (1) increase the DOE subsidy to the Hilo Training Center, (2) provide special funding for training of adults unable to compete with peers to earn a livelihood, and (3) give vigorous support for a multi-agency complex for the handicapped.

As a part of their annual health education program, the Honolulu County auxiliary sponsored a tremendously successful Guest Day Seminar in the mental health field. The seminar, "Two for the See Saw of Life," focused on human sexuality, family planning and marital bliss. A panel of prominent speakers aired all aspects of the topics with candor and frankness. An overflowing crowd of

384 representatives of civic, military, health and other community organizations, auxiliary members and guests kept the panelists busily answering an unending flow of questions. A portfolio of pertinent mental health articles and pamphlets compiled by auxiliary members was distributed to all those attending the seminar. Honolulu County also collected and distributed Christmas gifts for patients of the State Mental Hospital and the Waimano Home.

Program: The Program Committee headed by Mrs. George Schnack worked with real enthusiasm to create a Workshop Conference which proved not only stimulating but beneficial to all county auxiliaries. "Seizing the Times," a program of personal and organization development, was presented as well as workshops on (1) AMA-ERF, (2) Legislation, (3) Membership, and (4) Publication. A panel presentation, "The Emerging Woman," a topic apropos to the times, has been arranged for the annual Convention. An exhibit of arts and crafts by doctors' wives to show the many creative talents of our auxiliary members and a pre-convention Volunteerism Workshop led by Mrs. Betty McCain, national chairman of Volunteer Health Services, are being planned.

Publicity: Mrs. Rowlin Lichter has done a most effective job of getting publicity for our State Workshop and Conference. She is now hard at work seeking ways and means of obtaining publicity for our Convention.

Safety: The Safety Committee chaired by Mrs. O. D. Pinkerton cooperated with Honolulu County chairmen Mrs. George Kimata and Mrs. Danelo Canete in developing public awareness of poison prevention through the statewide distribution of 60,000 flyers. "Aid for Accidental Poisoning," and pamphlets, "Ten Little Tasters," to kindergarten and first grade children, Hawaii, Maui, Kauai and Honolulu counties all participated in this project. Poster contests were conducted at several schools on the fourth grade level. Prizes donated by drug companies were given for outstanding posters. Fifty American Pharmaceutical Association posters were distributed and displayed at drug stores, places of business and on hospital bulletin boards. 40,000 flyers, "Counter doses for the Home," printed by the Hawaii Pharmaceutical Association, were distributed through doctors' offices, primarily General Practitioners and Pediatricians. A proclamation declaring March 19-25, Poison Prevention Week, was signed by Governor Burns' aide in his absence. Radio and TV stations did spot announcements. Dr. William Moore appeared on the Don Robbs TV show and did an excellent job. Groundwork for next year includes a special teacher's manual in Japanese and Filipino languages. Foremost milk cartons featuring Poison Prevention and other special pamphlets.

GEMS, good emergency mother substitute, is a training program for SAFE baby sitting. The Hawaii County auxiliary will be conducting classes opened to high school students and adults in April. The course will cover the salient points of a proper job of baby sitting. Excellent study plans have been formulated, resource personnel have been lined up, eye catching posters have been displayed and the program is being well publicized via radio and press. GEMS certified baby sitters have been well received in our communities.

WA/SAMA: The WA/SAMA Committee under the leadership of Mrs. Ralph Hale sponsored a welcome brunch for newly arriving wives of medical students, interns and residents. Mrs. Hale, Mrs. Hay Roe and Mrs. Lichter have worked as liaison and advisors to the Aloha Chapter of WA/SAMA. WA/SAMA was formed to specifically help newcomers through the difficult stages of settling and adjusting in a new community. A Kokua Booklet which contains many helpful hints about where to shop and dine are given to all newcomers. Other WA/SAMA activities include a Luau, talk on Hawaiiana, visit to the Hale Mohalu Leprosarium. WA/SAMA members are invited to attend membership meetings and other special functions of the state and county auxiliaries.

Publication: "Rx for Doctors' Wives" is published three times a year. Co-editors, Mrs. Philip Lee and Mrs.

Charles Yamashiro, have done an excellent job. The selections of articles are not only timely but a delight to read. In addition to keeping the auxiliary members well informed of current activities, the "Rx" has done much to cultivate a sense of belonging and dedication to auxiliary aims and ideals.

While the bulk of this report dealt with the various service oriented committees, this in no way minimizes nor reflects on the officers and committee chairmen of internal affairs such as the hospitality chairmen, Mrs. James Nishi and Mrs. Keichi Goshi; finance chairman, Mrs. Richard Pang; historian, Mrs. Edward Yamada, and parliamentarian, Mrs. Varian Sloan; our secretaries, Mrs. Richard Mamiya and Mrs. Henry Yim, and our treasurer, without whom we wouldn't be able to function, Mrs. Walter Char. They all worked diligently, effectively and quietly, a marvelous team all working hard to help accomplish all the activities reported above.

It has been a most productive year and all of the credit for the many accomplishments are due to the efforts of all the hard-working officers, committee chairmen and members. Finally, I would like to take this opportunity to thank our HMA Advisory Committee who stood on the ready to help us and to the HMA Council for allowing me the privilege of sitting in on their deliberations. It was a heart-warming experience to witness the selfish dedication of the council members and their desire to constantly upgrade all facets of medicine and public health.

RECOMMENDATIONS:

- (1) That all auxiliary chairmen be invited to sit on corresponding HMA committees where auxiliary may be of possible service to the committee
- (2) That HMA Legislation Committee suggest ways in which auxiliary might help the Committee.

MRS. SYDNEY FUJITA

Woman's Auxiliary President

Your Reference Committee next considered the report of the Woman's Auxiliary President. A full and complete discussion was held. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLICATIONS

The HAWAII MEDICAL JOURNAL now has a new Associate Editor, Mr. Paul Steward. He replaced Mrs. Marilyn Wall, who left the Islands. Mr. Steward was hired on a part-time basis (roughly 1/4 time). He has had considerable experience, having worked with the Star-Bulletin Printing Plant and is familiar with the mechanics of journal work.

After the Guam Medical Society was accepted as a component member of the AMA, their President expressed an interest in making the HAWAII MEDICAL JOURNAL the official journal of their society. The Committee agreed to provide the HAWAII MEDICAL JOURNAL to the Guam Medical Society with the condition that they provide the copy for the page or pages, and pay for whatever means of transportation they desire for shipment of the JOURNAL to Guam. However, negotiations fell through.

Because of the difficulty of keeping up with the writing of obituaries in the JOURNAL, the Committee suggested that obituaries be run like a small capsule of news similar to those in the AMA Newsletter.

The Committee considered the request of many physicians to list their sub-specialties in the new HMA Roster. It was felt that this practice was not in accordance with the policies of the AMA. HMA's previous policy has been to limit the specialty to AMA acceptance. It was, therefore, decided that the HMA Roster conform to the AMA Directory.

The Committee recommended that the subscription rate

of the HAWAII MEDICAL JOURNAL be increased to \$8.00 per year from the previous \$6.00. This was necessary due to increased printing costs.

RECOMMENDATION: That Dr. Harry L. Arnold, Jr. continue as the Editor of the HAWAII MEDICAL JOURNAL.
L. Q. PANG, M.D.

Publications

Your Reference Committee considered the report of the Publications Committee. A full and complete discussion on the subject was held. Your Committee notes that in Paragraph 1 "Associate Editor" should be changed to read "Executive Editor." Your Committee recommends approval of this report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS COUNSEL

Since becoming affiliated with the Association in October, 1971, Public Relations Counsel has been utilized for professional advice and direction only, rather than as a panacea for any and every problem that arose. Among Counsel's original recommendations to the Association, after observing the various committees in operation, was that the Association utilize the manpower and resources available within itself to generate and conduct a Public Relations program.

With this thought in mind, and after Counsel met informally with various members of the news media, the use of a physician assigned to each major medical reporter (to act as that reporter's medical news advisor) was reinstituted with good results and favorable comments from the reporters included. Counsel continues to sound out these reporters to see what other problem areas might exist and how better press relations can evolve.

Again, believing that good public relations and communications start within the organization itself, Counsel has met regularly with the Public Relations Committee to advise and direct the Committee, rather than displace or duplicate its function. Among recommendations made to the Committee were:

1. That to improve communications within the Association, and particularly between the various committees, the Public Relations Committee consider reorganizing itself. The reorganized Committee could be formed primarily of representatives of various other working committees within the Association. This would, in effect, make the Public Relations Committee a forum where ideas and reports could be exchanged. This would assure that duplication of effort would not exist among different committees and certainly would broaden all members' knowledge about the many areas the Association is actively involved in.
2. That good public relations begin at home. Whether that home be the Association or, more importantly to the individual physician, at the "place of business." It is Counsel's belief that if all members could be kept fully informed about the purpose, organization and functioning of the Association, that good public relations about the Association would naturally flow from these members. If all members actively participated in the Association and utilized the resources available to them, the pride they would feel about the Association would generally be reflected to the press. If, on the other hand, there is resentment, discontent and lack of understanding, poor press will result.
3. In this era of competition, and socialization, each physician must make a concerted effort to project a favorable "image" to his patients. They are, taken individually, the public we are trying to

impress with our professionalism. Satisfaction with the physician's services, the office procedure and of course the cost will go a long way toward improving the "image" of organized medicine to the public. These are areas in which the individual physician can exercise various degrees of control, and certainly should not abdicate this control to someone not vitally interested in the profession.

PAUL STEWARD

Public Relations Counsel

Your Reference Committee considered the report of the Public Relations Counsel. A full and complete discussion on the report was held. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS/NEWS MEDIA

During the past year, your Public Relations Committee has continued to meet as needed—monthly and even more frequently for a few special meetings. They have a good start on a renewed and updated Medical Opinion Questionnaire for intramural use. They have finalized the Code of Cooperation, developed guidelines for telephone listings, begun guidelines for an initiation and investiture procedure and weathered a few rocky PR problems.

The troika of HMA PR Committee Chairman, HCMS PR Committee Chairman, and HMA News Media Committee Chairman has apparently worked quite well and it is recommended that this be continued as a *de facto* committee with co-chairmen.

Dr. Chinn has initiated a line of information which includes the presence of the PR Committee Chairman on many of the Council meetings for information purposes.

To increase the free flow of information, new criteria for appointing members of this Committee have been forwarded to the Council, suggesting that it be made up of representatives from each of the working committees of the HMA.

The services of a PR professional have been inestimable. Mr. Paul Steward has filled this position during the year. I encourage the continuance of this position and would hopefully expand the use of this gentleman to as nearly fulltime as we can afford.

We have assigned and established permanent liaison with many members of the press, using specific physicians assigned to them.

Journalism awards in the professional and educational division will be presented at the annual banquet.

It has been an active and interesting, as well as worthwhile, year.

RECOMMENDATIONS:

- (1) Urge formal acceptance by the HCMS of the combined PR-News Media Committee
- (2) Appoint the PR Committee Chairman as a non-voting member to the Council
- (3) Change membership of PR Committee to be representative of all working committees
- (4) Continue the professional PR Counsel
- (5) Spin off the internal affairs duties of the PR Committee as a separate committee or the duties of a paid member of the executive staff
- (6) Urge adoption of the finalized Code of Cooperation by the news media
- (7) Adopt in principle a formal initiation into the Medical Association
- (8) Eliminate the educational division of the news media awards because of poor response and increase the amount of the award in the professional division.

BUDGET REQUEST:

Public Relations:	
PR Counsel	\$4,000.00
Key-punching of Opinion Survey....	250.00
TOTAL	\$4,250.00
News Media Awards:	
Professional Division:	
First Prize	\$ 500.00
Second Prize	250.00
TOTAL	\$ 750.00

ROWLIN L. LICHTER, M.D. AND
HENRY YOKOYAMA, M.D.

Public Relations/News Media

Your Reference Committee considered the report of the Public Relations and News Media Committee. A full and complete discussion on the subject was held. The budget request of this joint committee is reflected in the Treasurer's Report. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

QUACKERY

The Quackery Committee met several times during the past year. No major examples of quackery, other than chiropractic, have been presented. An attempt was made to introduce legislation which would have curtailed the practice of chiropractic. Currently, another approach at limiting the impact of chiropractic by at least toning down the flamboyant advertisements run in the local newspapers is being considered. The Quackery Committee should continue to function on call as the need arises.

WILLIAM H. SAGE, M.D.

Quackery

Your Reference Committee considered the report of the Quackery Committee. A full and complete discussion on the subject was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM

The central theme for this year's Scientific Meeting is "Pathology as it Relates to Clinical Practice." Speakers for the program were selected by the Committee and commitments were obtained by October, 1971.

Six lecturers from the mainland and one local speaker were invited to present the scientific program. Four local physicians will participate in a panel discussion led by one of the invited speakers. This year's scientific program follows the 1971 pattern which allowed physicians to attend one of three lectures.

The Thoracic Society again planned the Tuesday night "Fireside Chats."

Mr. Harold Brown of the Conference Center, University of Hawaii College of Continuing Education and Community Service, again provided coordination of the program and made arrangements for all of the physical facilities. The Conference Center continues to be extremely helpful in assisting the Committee with various details such as printing of the program, audio-visual services, registration procedures, and travel and hotel accommodations for guest lecturers.

Grateful acknowledgment is made to the following organizations whose contributions made the program possible: American Cancer Society, Hawaii Division, Inc., Bristol Laboratories, Burroughs Wellcome & Company, Inc., Ciba Pharmaceutical Company, Eli Lilly and Company, Geigy Pharmaceuticals, Hawaii Heart Association, Hawaii Thoracic Society, Parke Davis & Company, A. H. Robins Company, Roche Laboratories and Sandoz Pharmaceuticals.

Acknowledgment is also made to those Hawaii Medical Association members who have graciously agreed to appear on the program as speakers, moderators, presiding officers, and host physicians.

At a combined meeting of the Scientific Program Committee and the Arrangements Committee, the theme "Clinical Pharmacology and Therapeutics" was selected for the 1973 meeting and will be presented to the HMA Council for approval on April 14, 1972.

RECOMMENDATIONS:

- (1) That program planning for the 1973 theme of "Clinical Pharmacology and Therapeutics" be continued as early as possible
- (2) That the Committee continue to work closely with the Conference Center and utilize their expertise in convention planning
- (3) In planning the scientific program in prior years, it appeared that speakers who are highly in demand were booked up at least 12 months in advance and so it is recommended that we plan at least 18 months in advance to invite speakers. The theme of the scientific program should be selected from 1½ to 2 years in advance for the next two or three meetings.

HERBERT S. UEMURA, M.D.

Scientific Program

Your Reference Committee considered the report of the Scientific Program Committee. After a full and complete discussion, your Committee recommends approval of this report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TELEVISION-RADIO

The Committee has had a most difficult and trying year, but with prospects of a most exciting year ahead.

On January 27, "Medically Speaking" closed out on KHET. Less than a month earlier, the TV Committee was notified of the fact, though the decision had been made about six months previously to discontinue "Medically Speaking." Reasons given for discontinuing "Medically Speaking" were: (1) pressures from other professions, (2) lack of station personnel/funds, (3) the feeling that the repetition of topics loses the audience.

Immediate discussions with KGMB-TV President, Cecil Heftel, confirmed poll evidence that "Medically Speaking" was indeed a popular and viable program of community interest. Plans were then formulated to produce "H.M.A. Hotline" as the successor to "Medically Speaking," with an agreed emphasis on controversial topics of community, and medico-social interest. As a public service, free time on Sunday at 1:30 p.m. was given to "H.M.A. Hotline" with a viewing audience 3½ times greater than previously. Although air time was given free, production time had to be paid.

The first program of "H.M.A. Hotline" was on March 12, 1972 with plans to continue the program on a weekly basis, without a summer break. Production facilities, station cooperation and professional assistance has been most impressive, especially from Mr. John Kernell, pro-

ducer for the program. The Committee is most optimistic that "H.M.A. Hotline" will be the best ever of H.M.A.'s TV programs.

The price for this improved and more popular program extending through the summer is a budget about three times larger than previous. Funds are being vigorously sought from various sources to help defray this community-service program. Approximately \$10,000 will be sought yearly to meet the increased budget for "H.M.A. Hotline."

The TV-Radio Committee has also offered its assistance to Cable TV, Channel 6, and has assured KHET-TV that it would be happy to cooperate in the production of TV specials on medical topics.

The Message of the Month continues to emanate from this Committee through Dr. William Moore's efforts.

BUDGET REQUEST—January-December, 1973:

Production costs (KGMB)

@ \$200 for 52 weeks	\$10,400.00
Salary—Moderator (G. Burke)	
@ \$50 for 52 weeks	2,600.00
Salary—Question Central (B. Darr)	
@ \$40 for 52 weeks	2,080.00
Message of the Month—	
\$100 for 12 months	1,200.00
Transportation (Neighbor Island	
M.D.s)	300.00
Refreshments/food for V.I.P.s	200.00
Visual Aids—\$25 × 52 weeks	
(slides, charts, 16mm)	1,300.00
Video tapes—3 @ \$150	450.00
TOTAL	\$18,530.00

RECOMMENDATIONS:

- (1) HMA discontinue the ads in the Sunday TV Guide for "H.M.A. Hotline" temporarily
- (2) HMA continue "Message of the Month" if financially feasible
- (3) HMA continue to encourage Neighbor Island M.D.s to participate on "H.M.A. Hotline"
- (4) HMA continue to solicit funds and donations to assist in the production of "H.M.A. Hotline"
- (5) HMA recognize and thank Mr. Cecil Heftel of KGMB for his interest and enthusiasm in producing a community affairs program of medical interest.

THEODORE K. L. TSEU, M.D.

TV-Radio

Your Reference Committee then considered the report of the TV-Radio Committee. A full and complete discussion on the subject was held. Your Committee notes that in Paragraph 3 Line 8 the time of the program should be changed from 1:30 P.M. to 2:00 P.M. Your Committee recommends deleting Recommendation No. 2. Your Committee further recommends approval of Recommendation Nos. 1, 3 and 4. Your Committee also recommends that Recommendation No. 5 be changed to read "That the HMA President or Council write a letter recognizing and thanking Mr. Cecil Heftel of KGMB for his interest and enthusiasm in producing a community affairs program of medical interest." This committee's budget request is included in the Treasurer's Report. Your Committee recommends approval of this report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. Dr. Tseu asked that the 1972

budget request be deleted from the report. The report was adopted as amended.

WOMAN'S AUXILIARY

The purpose of this Committee is to serve in an advisory capacity to the Woman's Auxiliary. It was not necessary for the Committee to meet during the past year.

EDWARD L. CHESNE, M.D.

Woman's Auxiliary

Your Reference Committee considered the report of the Woman's Auxiliary Committee. A full and complete discussion on the subject was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 6 AS ADOPTED

Re: Woman's Auxiliary

WHEREAS, the Woman's Auxiliary has worked hard and long to raise funds for the AMA-ERF, and

WHEREAS, some contributions have been made other than through the Woman's Auxiliary, now therefore be it *Resolved*, that all contributions to the AMA-ERF made by physicians in Hawaii be contributed through the Woman's Auxiliary of the Hawaii Medical Association and that the AMA be notified of this action.

EDWARD L. CHESNE, M.D.

Resolution No. 6

Your Reference Committee then considered this Resolution pertaining to physicians' contributions to AMA-ERF. Your Committee fully concurs with the intent of this Resolution and recommends its approval.

ACTION:

The Chairman recommended that Resolution No. 6 be adopted. There were objections. A motion was made to amend the *Resolved* of Resolution No. 6 as follows: "... contributions to the AMA-ERF made by *HMA-member physicians*." The motion was not seconded.

The Chairman recommended that Resolution No. 6 be adopted. It was adopted.

ACTION:

The Chairman moved adoption of the report as a whole. It was adopted.

UNFINISHED BUSINESS

The President asked if there were any unfinished business to come before the House. The following resolution was presented:

RESOLUTION NO. 10 AS ADOPTED

Re: Herbert Y. H. Chinn, M.D.

WHEREAS, Herbert Y. H. Chinn, M.D., has completed his term as President of the Hawaii Medical Association, and

WHEREAS, he has been an inspirational, untiring force in causing the Association to assume the lead in attempts to resolve many of today's issues concerning health, and

WHEREAS, he has involved the Hawaii Medical Association in community affairs and projects in an effective, meaningful manner, and

WHEREAS, he has reflected the entire medical profession in a most honorable and appropriate way, serving his colleagues well, now therefore be it

Resolved, that the 1972 House of Delegates of the Hawaii Medical Association commend Herbert Y. H. Chinn, M.D., for his outstanding contributions to the Association as its President, and be it further

Resolved, that this resolution be read at the Annual Banquet.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

ACTION:

A motion was made to adopt Resolution No. 10 by acclamation. It was adopted and President Chinn was given a standing ovation.

RESOLUTION NO. 13

The President ruled that Resolution No. 13 was not germane to the purposes and objectives of the HMA and declared the resolution out of order.

ACTION:

A motion was made and seconded to appeal the decision of the President. The motion was defeated.

RESOLUTION NO. 14 AS ADOPTED

Re: Interim Session Informing Membership on National and Local Care Issues

WHEREAS, it is essential for members of a professional body to be well-informed on national developments affecting the practice of medicine, and

WHEREAS, there are many proposed and currently developing issues regarding medical care delivery in federal legislative bodies, and

WHEREAS, peer review and other review mechanism already being proposed by nonphysician bodies and it is essential that the profession remain in control of this function, and

WHEREAS, there are numerous proposals which alter the present health manpower and facilities interrelationships, and

WHEREAS, much interest has been expressed concerning the desire of the membership to keep informed in these areas, now therefore be it

Resolved, that the Hawaii Medical Association approve of the concept of an interim session being held, for the purpose of informing the membership about national and local trends or issues affecting the delivery of medical care in Hawaii.

Submitted by THEODORE K. L. TSEU, M.D.

Resolution No. 14

Resolution No. 14 was presented to the House.

ACTION:

A motion was made and seconded that since Resolution 14 was not referred to a Reference Committee that action be deferred until the next House of Delegates meeting. The motion was defeated.

It was voted to adopt the resolution as presented.

NOMINATING

The Nominating Committee met once to receive nominations for needed offices of the Association. Dr. Thomas Frissell's resignation as Treasurer was accepted. The following slate of nominees was submitted to the Council at the February 25th meeting to be elected by the House of Delegates:

President-Elect.....	Thomas P. Frissell
Secretary.....	Ann B. Catts
	R. Varian Sloan
Treasurer.....	Grover H. Batten
	K. S. Tom
Councillors from Oahu..	H. William Goebert, Jr.
(Two to be elected)	George Goto
	J. I. F. Reppun

All nominees have been contacted and have agreed to serve if elected.

LIVINGSTON M. W. WONG, M.D.

Nominating

ACTION:

It was moved and seconded that the report of the Nominating Committee be accepted. It was voted to adopt the report.

The President appointed Drs. Katok Chuang, Denis Fu, and Winfred Lee to serve as tellers.

ACTION:

It was moved and seconded that the election for officers be held first or separate from the election of Councillors. The motion passed.

The President asked for nominations from the floor for President-elect, Secretary, and Treasurer (one-year term). Dr. H. Wm. Goebert, Jr. was nominated for Treasurer. No further nominations were offered. The results of the election were announced as follows:

President-elect.....	Thomas P. Frissell
Secretary.....	R. Varian Sloan
Treasurer (one year).....	Grover H. Batten

The President asked for nominations for Councillors from Oahu. No further nominations were offered and nominations were closed. Drs. George Goto and J. I. F. Reppun were elected as Councillors from Oahu.

The Nominating Committee was elected as follows: Herbert Y. H. Chinn, William W. D. Dang, George Ewing, Winfred Y. Lee, Robert A. Nordyke, DeWitt H. Smith (Hawaii), Katok Chuang (Kauai) and Sakae Uehara (Maui).

NEW BUSINESS

The President asked whether there was any new business to discuss. There was no new business and the meeting was adjourned at 5:30 P.M.

R. VARIAN SLOAN, M.D.
Secretary

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

June 2, 1972—5:00 P.M.

Mabel Smyth Conference Room

PRESENT

Dr. William E. Iaconetti presiding; Drs. Herbert Y. H. Chinn, Thomas P. Frissell, R. Varian Sloan, William W. L. Dang, George Goto, J. I. F. Reppun, Ed B. Helms, Sakae Uehara, Winfred Y. Lee, Denis Fu, DeWitt H. Smith, Ed R. Ballard, Albert Chun-Hoon, Douglas Bell II, Masato Hasegawa and Elisabeth Anderson plus Mrs. Schnack, Mr. Thorson, and Mr. Leineweber.

CALL TO ORDER

The meeting was called to order by President Iaconetti.

ELECTION OF THE COMMUNITY RESEARCH BUREAU

The Council recessed to hold the election of the Community Research Bureau. The following doctors were nominated for officers of the Bureau: B. Allen Richardson, President; Theodore T. Tomita, Vice President; O. D. Pinkerton, Secretary, and Grover H. Batten, Treasurer.

ACTION:

A motion was made and seconded that the Secretary cast a unanimous ballot for those nominated. The motion passed.

MINUTES

The minutes of the April 14, 1972, meeting were approved as circulated.

REPORT OF THE SECRETARY

Dues Refund: A letter was received from Hawaii County Medical Society regarding the recent death of Dr. Edward Wong and asking that his HMA dues be refunded to his family.

ACTION:

A motion was made and seconded that the Hawaii Medical Association refund their portion of the dues to Dr. Edward Wong's family and that the AMA be contacted to see if they will also issue a refund. The motion passed.

ACTION:

It was voted to approve the Secretary's report.

REPORT OF THE TREASURER

The financial statement for the month of April was circulated for information. It was pointed out that the \$1,500 for Miss McCaslin's Oahu Country Club membership still appears on the financial sheets and that no action has yet been taken. It was reported that no response had been received from Miss McCaslin to a recent request asking her to refund these monies to HMA.

ACTION:

It was moved and seconded that the HMA wipe this uncollectable debt off the books. There were objections to the motion. A motion was made

and seconded to amend the original motion by adding the following phrase at the end of the sentence: "and that Miss McCaslin be notified that the debt is being cancelled." The motion failed to pass. A motion was made and seconded to postpone this matter indefinitely. The motion failed to pass. The original motion passed.

Physician's Benevolent Fund: The President suggested that some action be taken in regard to the PBF fund. He suggested that a letter be written to all those who are listed as contributors asking whether they would want their fair portion refunded to them or turned over to the HMA general fund. A motion was made, but failed to receive a second, that those contributors be contacted and asked to contribute the monies for a building fund. Discussion indicated that using these monies for a building fund was a good recommendation but perhaps premature at this time.

ACTION:

A motion was made and seconded that the PBF monies remain as is for the following reasons: (1) there is no need for the monies right now, (2) the monies are accumulating interest and (3) that HMA abide by the original stipulation whereby the monies be allowed to accumulate to \$50,000 before they are used. The motion passed.

REPORTS FROM COMMISSIONS AND SPECIAL COMMITTEES

A. Committee chairmen: A list of committee chairmen was circulated for information.

Committees have been set up on a trial basis according to the structure recommended by the Committee on Commissions.

B. Bureau of Research and Planning election: Dr. Iaconetti submitted nominees for the Bureau of Research and Planning for Council approval. Following discussion relative to previous appointments and tenure, the following members were appointed to the Bureau and were approved by the Council: Masato Hasegawa, chairman; and Elisabeth K. Anderson, Samuel Allison, Richard Blaisdell, Claude Caver, Richard Mamiya, J. I. F. Reppun, Theodore T. Tomita, George H. Mills, George Henry, John Lowrey, Robert Nurdyke, Rowlin Lichter, Douglas Bell II, Lawrence Gordon, Namiko Kominami, Wallace Loui, Livingston Wong, and J. Mark B. Sowers. Two openings on the Bureau were left for members from Hawaii and Kauai Counties.

C. EMCRO appointee: Dr. Iaconetti announced that he had asked Dr. Frissell to serve in his place on the EMCRO Executive Board.

ACTION:

The Council voted to accept Dr. Frissell as the HMA representative to the EMCRO Board.

D. Careers Committee: It was suggested that the Careers Day program become a function of the Intraprofessional Liaison Committee.

ACTION:

The Council voted to accept the recommendation that Careers activities be a function of the Intraprofessional Liaison Committee.

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New Members



Joseph A. Brock, M.D.
1481 S. King St., Suite 539
Honolulu, Hawaii 96814

OBSTETRICS-GYNECOLOGY
McGill University School of Medicine
—1964
Internship—Highland Alameda
County Hospital—1964-1965
Residency—Queen's Hospital—
1965-1966
University of California at
Irvine Service
L.A. County Hospital, Unit II—
1966-1968
Orange County Medical Center—
1968-1969



John M. Corboy, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

OPHTHALMOLOGY
University of Illinois College of
Medicine—1963
Internship—Presbyterian—
St. Luke's Hospital—1963-1964
Residency—U. S. Public Service
Hospital, San Francisco—1966-1969



Denis T. C. Chan, M.D.
Waianae Medical Clinic
86-234 Farrington Highway
Waianae, Hawaii 96792

INTERNAL MEDICINE
Royal College of Surgeons &
Physicians, Dublin, Ireland—1966
Internship—Greater Baltimore
Medical Center—1966-1967
Residency—Coney Island Hospital—
1967-1968
V. A. Hospital, Bronx, New York—
1968-1969



Richard Lundborg, M.D.
c/o Hilo Hospital
Hilo, Hawaii 96720

ANESTHESIOLOGY
University of Minnesota—1959
Internship—Tripler Army Hospital—
1959-1960
Residency—Mayo Clinic & Graduate
School—1962-1965



Harold T. Machigashira, M.D.
407 Uluniu Street
Kailua, Hawaii 96734

GENERAL PRACTICE
University of Wisconsin—1969
Internship—St. Francis Hospital—
1969-1970



Ruth H. Matsuura, M.D.
1034 Kilauea Street
Hilo, Hawaii 96720

PEDIATRICS
University of California, S.F.—1954
Internship—Minneapolis General
Hospital—1954-1955
University of California, S.F.—
1955-1956
Residency—University of Minnesota
—1956-1957
University of Minnesota—1957-1958



Edwin P. Dierdorff, M.D.
30 Aulike Street
Kailua, Hawaii 96734

OTOLARYNGOLOGY

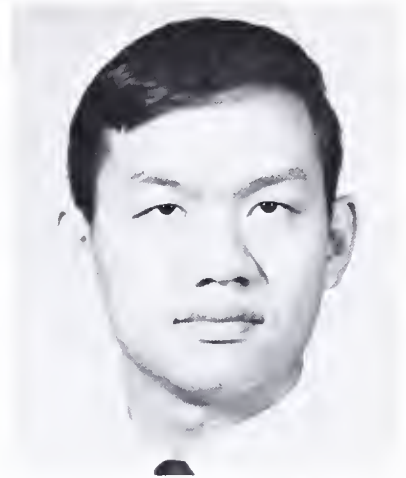
University of Colorado Medical
School—1962
Internship—Brooke General Hospital,
San Antonio, Texas—1962-1963
Residency—Ft. Ord, Army Hospital,
Ft. Ord, Calif.—1963-1964
Brooke General Hospital—1964-1967



Satoshi Kobayashi, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

NEUROSURGERY

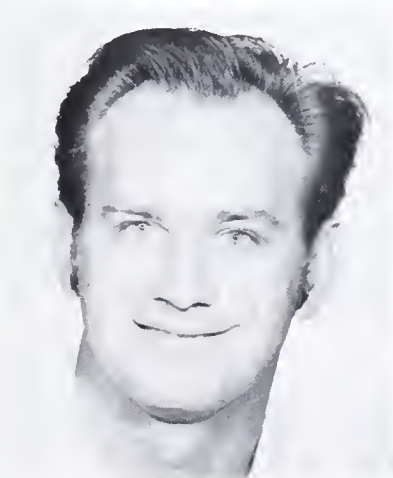
Shinshu University, Japan—1962
Internship—Okaya Hospital,
Nagano Ken, Japan—1962-1963
Residency—Barrow Neurological
Institute, Phoenix—1965-1970
V.A. Hospital, Los Angeles—
1970



James Lumeng, M.D.
2260 Liliha Street
Honolulu, Hawaii 96817

PATHOLOGY

University of Southern California—
1962
Internship—University of Illinois
Hospitals—1962-1963
Residency—University of Illinois
Hospitals—1963-1965
University of Chicago—1965-1969



Alexander Scott K. Miles, M.D.
133 Kionoole Street
Hilo, Hawaii 96720

INTERNAL MEDICINE

Creighton University School of
Medicine
Internship—St. Francis Hospital,
Honolulu—1965-1966
Residency—St. Francis Hospital,
Honolulu—1968-1970



**Winifred Jordan Simmons,
M.D.**
30 Aulike Street, Suite 506
Kailua, Hawaii 96734

PSYCHIATRY

Howard University School of
Medicine—1963
Internship—Highland Hospital,
Rochester, New York—1963-1964
Residency—St. Elizabeth's Hospital,
Washington, D. C.—1964-1967



Arch Wigle, M.D.
Naalehu Dispensary
Naalehu, Hawaii 96772

GENERAL PRACTICE & SURGERY

Wayne State University, College of
Medicine—1943
Internship—Metropolitan Hospital,
New York City—1942-43

Professional Moves

We note that *Homo Sapiens Medicus*, relatively quiet during Spring, is beginning to stir again with summer. In March, psychiatrist **Fred Pope** relocated to 1441 Kapiolani Blvd. In April, allergist **Peter Larm** opened a Hilo branch office at the Professional Building. Cardiologist **D. V. Reddy** and Ob Gyn man **Clayton Honbo** joined the Honolulu Medical Group, while another Ob Gyn man, **Kunio Miyazawa**, joined the Windward Medical Center. In May, dermatologist **Philip Hellreich** also joined the Windward Medical Center, while GP **Samuel Gringrich** joined the Waimea Medical Clinic. We also read the inspiring story of **Sam Wallis**, paralyzed after his aneurysm surgery last year, but back in practice at Wilcox Memorial Clinic and commuting between home and clinic on a golf cart refurbished by his Rotary Club friends. In June, **Ernesto Orinion** associated with **Walter Ozawa** at 21 Oneawa St., Kailua and internist **Yoshio Oda** relocated to 1441 Kapiolani Blvd. In July, dermatologist **Paul Sunahara** relocated to the Professional Center Bldg.

On the Health Dept. front, psychiatrist **Francis Pritchard**, who had practiced seven years in California and more recently on Yap, was appointed to the West Hawaii Mental Health Clinic. **Ned Wiebenga**, retired Public Health Service officer, became the State's new epidemiologist, a post vacant for over a year.

Anyone worrying about our peripatetic neurosurgeon **Ralph Cloward** will be relieved to know that he is safe aboard the good ship *Hope*, anchored 11 months off Natal, Brazil—where there's 1 doctor for 14,000 people. That should keep Ralph busy awhile. . . .

Quotable Quotes

Albert Kattus, visiting cardiologist from UCLA, described the treadmill stress test as: "The most definitive prognosticator for cardiovascular disease."

Ed Childs told the story about a radiologist discussing the x-ray findings on a patient with possible abdominal pathology and noting that the surgeon's eyes suddenly "became slits like two Bard Parker blades."

Life in These Parts

A Belgian lass with impish charm, married to a local fellow, was a recent immigree to the islands. Her English was faltering, but most remarkable and descriptive for its lack of adequate vocabulary. She gave symptoms of dysuria, vaginal discharge and dyspareunia (which she described as "hurting like hell . . . not enjoyable, but that's not what I mean"). We did a pelvic and noted the usual discharge associated with vaginitis. As she removed her feet from the stirrups, she asked casually, "Is the machine still in?" Enchanted by her picturesque language, we had forgotten to check for her IUD. So back up the stirrups. We found the telltale string camouflaged in the discharge and before we could emerge, came a booming voice from up above, "How is the situation down there?" We reassured her. During the rectovaginal exam, we had noted a definite anal sphincter tenderness and asked, "Do you have piles?" "No," came the honest reply, "But I have pain, because I have hemorrhoids."

Later, we commented about a new thumb nail growing and she explained with gestures how she had gotten off a cab and slammed her thumb in the car door. The cab driver was about to drive off so she frantically tried to explain her plight to the driver who was also a foreigner (probably a Filipino, we gathered) who could not understand her accent. She lost precious painful minutes in the communication gap and when she finally broke into tears, the driver understood. We tried to explain how delightful the situation comedy was, and she concluded, "You are pulling my leg, no? That's English, not American, yes?" We assured her that it really didn't matter, whether it was American or English, but conversing with her had been a most delightful experience.

The day after the annual Kuakini staff party at Natsunoya tea house, where stripper Sherry Hamons and belly dancer Shalimar added zest to the festivities, **Mike Okihiro** complained to ENT man **Hideo Oshiro**, "Say, I don't know about your ENT colleagues. . . . **Walter Young** sat next to me and all he noticed was that the stripper has a long nose." (Methinks we should occasionally forget our specialties.)

While **Harry Nakata** was recovering from a mild MI, we would drop in to chat for a few minutes during rounds despite the "No Visitors" sign posted outside his private room. Only later did we realize how much he appreciated our visits for we received the following card. "Just a short note to let you know how much I appreciated your frequent dropping by to chat with me. These chats really helped my days pass over swiftly and were welcome breaks in an otherwise dull routine day. . . ." (Ennuui could perhaps be more harmful than disease itself. . . .)

Harry Arnold, Jr.'s latest recipe for all insect bites . . . meat tenderizer. . . . Harry relates how surprised fellow dermatologist **Harold Johnson** was at the instant relief when he applied the meat tenderizer to his bee sting.

Grover Batten of late looks 20 lbs. slimmer and at least 10 years younger. When we inquired, "What's the secret?" he replied, "Maybe it's the sinful life I lead. I go to bed every night."

Worrying about our thinning tops, we recently asked dermatologist **Dan Palmer** if there was any new remedy. Dan replied blandly, "You can do something about preventing any further thinning." "What's that?" we asked hopefully. The reply was terse, "Castration."

As he took a mouthful of fresh oysters on the half shell, food faddist **Jerry Faulkner** commented, "Eat fish and live longer. . . . Eat oysters and love longer." (Overheard at a Medicare Review meeting at the Whaler's Broiler.)

St. Francis Golf Tournament Banquet

We happily accepted co-chairman **Bill Dang's** invitation to the post tournament gourmet banquet at King's Garden. The annual St. Francis Golf Tournament has always been the talk of the medical community because

all participants win fabulous prizes and the winner traditionally gets ribbed something awful. . . . General chairman **Al Chnn Hoon** explained that co-chairman **Catalino Cachero** was being renamed "Sandy" after he hit 23 traps at Kulima in 18 holes of play. So frustrated was "Sandy" that he got drunk after the game with **Cora Manayan**. We wondered at all the non-golfers present at the affair and learned that they were the contributors who made possible this richly endowed tournament. Acknowledgments went to **Cliff Chock**, who received a pen and peneil set "so that he can write an even bigger check for the next tournament." Others acknowledged were **Wini Lee**, **John Takamura**, **Herbert** and **LQ Pang**, the Path Associates, the Hawaii Neurological Clinic, the Chock Pang Clinie and the Radiology Associates.

MC **Bill Dang**, commenting on the movie takes, described good natured **Cora Manayan** as "the official mascot of the tournament," and **Richard Ilo** as the "dancer" (because of his graceful footwork). When he ribbed **Henry Fong** for an unorthodox swing, **LQ Pang** lashed back with, "You guys laugh, but look who won." **Arturo Saleedo** was described as "Hollywood" because of his dark glasses and as "the golfer with the most beautiful swing." **Al Paraz** was "Gorilla" because of his size and powerful strokes. When **John Takamura** swung away, Bill commented, "Watch his full body swing" and **Wini Lee** added, . . . "A good samurai profile." The photographer with his zoom lens later caught John, unaware, relieving a full bladder in the brush. The 3-minute take was complete in detail, to the final shake. Bill commented, "Note how he shakes away from the wind? The last time he gave a final shake against the wind, he felt something warm down his pants leg. . . ." **Ed Kagihara**, who came in second, and describes himself as "Always the brides maid . . ." commended John for his performance with "You win the Academy Award."

"Sandy" Cachero gave the special awards, a towel to **John Takamura** with the Golfer's Prayer inscribed, "I've had pars and birdies—eagles too, during days of golfing fun. But Lord, just once, I pray to you, Grant me a hole-in-one." **Glenn Kokame**, who had lost his winning streak of late, had a bad two days and received a "Crying Towel."

The winner, **Henry Fong**, was ribbed mercilessly by **Bill Dang**, who was simply returning some of the ribbing he himself received for winning several years in a row. Henry finally got up and said, "The strangest thing happened to me Monday morning . . . (ie after the weekend tournament). . . . Someone mistook me for **Bill Dang**."

Jimmy Young, who last year had won the "Fickle Finger of Fate" award (a beautiful mahogany carving of a hand with the index finger pointed heavenward) reluctantly gave it up to **Young Paik** for his high gross of 159, but others in **Henry Fong's** foursome wanted to award it to Henry for his ecstatic "whoooooe's" whenever he made a spectacular shot.

Some of the scores were as follows: **Henry Fong** won with a two day net of 131, while **Tom Kobara** and **Ed Kagihara** were tied at 2nd with nets 139. Close behind was **Allen Young** with a net 140 and in 5th place, **Sam Yee** with net 143 (Sam also won low gross honors with 163). Swinging **Paul Tamura** was 6th and in a miserable 7th place was **Bill Dang** (our traditional grand slam winner). **Arturo Saleedo** and **Jimmy Young** (last year's high gross winner) were tied for 8th, while **Wini Chang** was 10th. **Herman Mercado** was 11th, **Ben Realica** 12th, **Clarence Sakai** 13th, "Big" **John Takamura** 14th, **Al Chnn Hoon** 15th and **Ed Lau** 16th. **Fred Lam, Jr.**, who just took up the game, placed 25th place (and still won a ping putter.)

Catalino Cachero was given **Herb Pang's** special award, a "Portable Sand Trap," and **Francis Oda**, who admits "I really blew" and shot a 105 gross, received the "Sportsman of the Year" award for keeping his cool after taking 6 strokes to get out of a trap. When **John Takamura** kept removing sand from around his ball with his sand wedge prior to swinging, **Ray Fujikami** warned, "You no hapapu the ball in the trap."

Lup Pang commented that he will recommend to the executive committee that St. Francis Hospital declare a special "Henry Fong Day."

Ed Lau apparently hit the wrong ball, but **Sandy Cachero**, who was his partner, reassured him, "It's OK! There is no penalty at Waialae Country Club."

Some of the jokes we garnered were as follows:

Bill Dang told a 'Tom Thorson' joke: "Said the prostitute to the midget: 'Keep your nose out of my business.'"

KS Tom (resplendent in a blue Mao jacket) told the joke of a golfer marooned on a desert island for many years. Finally one day a raft reached the island with a beautiful blonde. Seeing how bleak things were on the island, the blonde first asked him if he wanted any cigarettes. He nodded weakly so she went back to the well stocked raft and got him a carton of cigarettes. He immediately lighted one up and began to brighten—She then asked, "How about some Scotch?" He nodded stronger approval and she went back to the raft and got him a bottle. He gulped down a few jiggers and began to come alive. The sympathetic blonde, feeling pity for the lonely man marooned so long, asked, "How would you like to play around?" Despite the beard, the eyes brightened fiercely, and he asked happily, "You mean you have a set of golf clubs on the raft too?"

Elected, Appointed, and Honored

We committed the unpardonable sin of neglecting this little item in the last issue . . . we physicians especially need a little recognition from time to time to boost our little fractured egos. . . . We reach back to March when the Pan Pacific Surgical Association elected **Richard Moore** as treasurer and **Albert Chnn**, **Bill Goebert, Jr.**, **Charley Judd** and **O. D. Pinkerton** to the Board of Trustees. Also in March, **Charley Judd** was elected a trustee of the Hawaiian Historical Society at its 80th annual meeting. **Helen Percy** of the Maui Medical Center became "the only woman ring physician in the world" when she was appointed physician for the professional boxing card on Maui at the War Memorial Center arena. . . . Women's lib, eh? In April, the State Senate confirmed the appointments of **Timothy Woo** and **Henry Manayan** to the Board of Medical Examiners and of **Perry Sumida** and **Roger Brault** to the Medical Advisory Board. The HMSA elected **William Wilkinson** secretary and **Cesar De Jesus**, **William Goodhne**, **James Nishi** and **Ralph Hook, Jr.** to its board. **Calvin Sia** was reelected chairman of the Variety Club School board and **James Fleming** was named "Layman of the Year" by Kiwanis Club of Maui.

In May, of course, we had our own HMA elections with **William Iaconetti** of Lahaina installed as president, succeeding **Herb Chinn**. **Tom Frissell** was elected president-elect, **Varian Sloan** continues as secretary, and **Grover Batten** was elected treasurer. **George Goto** and **Fred Reppun** became the new councilors from Oahu. At the HMA banquet, **John Lowrey** was announced as the AH Robin "Physician of the Year" "amid the roar of a standing ovation." We can't think of someone more deserving. Also in May, **Masato Hasegawa** was selected chairman of the Professional Division of the 1972 Aloha United Fund drive.

On the academic front, we have three new Fellows of the American College of Physicians, **David J. Andrew**, **Bernard W. D. Fong** and **John H. C. Kim**.

Medical Tidbits

Coffee Room Dialogue:

"I have a strange case."

"What's that?"

"This patient swallowed a 5 dollar bill. I have treated him for a whole week. . . ."

"What's so strange about the case?"

"No change. . . ."

continued page 346

County Society News

HAWAII MEDICAL JOURNAL

Honolulu

The May 2 meeting was called to order by President Winfred Lee. He welcomed and introduced to the membership new members, Drs. Denis Tsin Chung Chan, John Medford Corbon, and James Lumeng.

Minutes of the April 4 meeting were approved as read by Dr. William Moore.

Mr. Albert Yuen, Administrative Vice President of HMSA, was speaker for the evening. Mr. Yuen presented a capsule view of HMSA as an organization and discussed the concepts of HMOs; *Usual, Customary, and Reasonable* method of compensation; Peer Review and Utilization Review. Assisting Mr. Yuen in answering questions were Dr. Toru Nishigaya, Ralph Kisling, and Marvin Hall.

Dr. Lee reported that the *Ad Hoc* HMA-Beverly Payne Study Committee consisting of Drs. Iaconetti, Reppun, Chinn and himself went over the entire study that was made available to the committee. This committee was appointed to make an evaluation of the study and several conclusions were drawn from the data compiled by Dr. Payne. He stated that the primary purpose and function of this study is to provide information on the quality of personal medical care in Hawaii. It would seem that at present, until we define exactly what the term "quality medical care" means, we do not have a measurement of the quality of medical care, and a complete measure of the quality of medical care is yet to be developed.

Dr. Lee brought out that there has been some discussion by the Board of Governors about the poor attendance at membership meetings and a number of ways to increase this attendance has been proposed. It is possible that we may have to go back to compulsory meeting attendance and if this was done, the burden of planning for better programs would fall upon the Board of Governors and Program Committee.

Dr. Lee also announced that PMMS have come up with a new package for the doctors which will make it more competitive price wise. Action on this new pricing will be taken by the BME Board.

Maui

President Fu called the meeting to order at 7:05 p.m., preceded by a few strikes of the fork on a glass to attract the members' attention. Meeting was held at Club 19 on June 20, 1972. Members present were: Doctors Achong, Briley, Burden, Dietrich, Fleming, Fu, Haling, Hariharan, James, McCollum, Moran, Morris, Peat, Romero, Sowers, Uehara, Underwood and Withers.

A letter from Dr. T. Chang thanking the Maui County Medical Society for the opportunity of speaking about the EMT (Emergency Medical Technician) program last May was read. Dr. Uehara reported that the request of HMA for a grant to train ambulance attendants was approved by RMP (Regional Medical Program) for \$3½ million to be spent on the following projects: 1) radio telemetry, 2) training of Emergency Medical Technicians, 3) improvement of emergency medical services, and 4) community education through HMA, Department of Education. Dr. Livingston Wong will be in charge of training the ambulance attendants.

It was moved, seconded, discussed and approved (Morris, Sowers, Uehara) that our councilman collaborate with the Maui Memorial Hospital administrator, Mr. Romson, to determine our needs not only for ambulance training here, but also to update our emergency room facilities and apply for the necessary funds.

Dr. Withers announced the forthcoming visit to Maui of the internationally renowned vascular surgeon, Dr. Ed. J. Wiley of the University of California, San Francisco, who will speak on extracranial cerebrovascular occlusions.

Dr. Uehara reported that the proposal for an Advisory Board of Consumers in the Council was rejected.

Dr. Uehara read the guidelines on the Publicity Code for Physicians and the principles of replying to Media questions were briefly discussed.

Peer review was discussed. Medical groups with their own review committees should not be eligible for PRSO, to erase doubts about the group's financial interests. Dr. McCollum deplored the inaction of the state to previous plans. Dr. Sowers suggested that we develop our own plan until the State has worked out a plan for the entire state. Dr. Winnie Lee is now working on this problem.

During the discussion on the proposal for retiring Pioneer Mill workers, mention of the OEO (Office of Economic Opportunity) contract with Kaiser in Oahu was assailed by some members.

Dr. Moran cautioned the members that before contributing to the Cutting Memorial Fund, we should first know how the funds will be expended.

In connection with other contributions, our Councilor and Delegate to AMA announced that all contributions to the AMA-ERF should be channeled through HMA Women's Auxiliary to determine how much money is coming from Hawaii.

When President Fu introduced the HMO question, repercussions developed. Dr. Withers related the frustrating experience of a friend of his who after joining the Maui Medical Group HMO found no free choice of doctors and when he (the friend) wanted to back out, he was told that he could only do so after one year. Dr. Romero also mentioned that he had some patients in the same predicament.

Dr. Burden contends that the intention of HMSA is to prevent infringement upon free choice. The possibility of error in communication on the part of the local HMSA manager was entertained.

After additional remarks from Doctors Moran, Morris and McCollum, it was decided that grievances or charges should be expressed in writing and would then be acted upon by the County Society's Committee on Adjudication.

Dr. Sowers poured water on the burning HMO issue by rising on the point of information (on another subject but no objection was expressed by the chair or the floor). The CHP (Comprehensive Health Planning Subcommittee on Fluoridation) has given up asking politicians for action so the former have decided to ask petitions (3,000 at least) to include the question in a referendum.

President Fu adjourned the meeting at 9:10 p.m.

We sure missed the following members: Doctors Allred, Andrews, Azman, Behnke, Hanlon, Howell, Iaconetti, Izumi, Kushi, LaFon, McDonald, Moser, Ohata, Patterson, Percy, Pfaeltzer, Rockett, Rossberg, Strother, Tofukuji, Weeks and Wong.



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HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: EDMUND E. EHLKE, *Vice President:* JAMES MCELHANEY, *Secretary:* MARY McMILLAN, *Treasurer:* LAUREN WONG, *Board of Directors:* WALTER HARANAKA, EARLE SANDISON, HENRY URASHIMA, JAMES ASATO, WALTER KAM, GRACE MIYAWAKI, HONG TING CHEE and KARL MILLER.

New Officers Installed

The Annual Installation and Awards Banquet of the Hawaii Pharmaceutical Association was held on Friday, June 30, 1972, at the Tripler Hospital Officers Club.

James Yamauchi was Master of Ceremonies; Mr. Fritz Herman, former general manager of Kodak-Hawaii, was the after-dinner speaker; and Lt. Col. Wm. Guthrey, chief pharmacy officer at Tripler Hospital, installed the new officers for the 1972-73 year.

Officers of both the Hawaii Pharmaceutical Association and the Hawaii Society of Hospital Pharmacists were installed. The new officers of the Hawaii Pharmaceutical Association are:

President: Edmund E. Ehlke

Vice President: James McElhaney

Secretary: Mary McMillan

Treasurer: Lauren Wong

Board of Directors: Henry Urashima, James Asato, Hong Ting Chee, Walter Kam, Grace Miyawaki, Karl Miller. Directors remaining from last year—Walter Hiranaka and Earle Sandison.

New officers of the Hawaii Society of Hospital Pharmacists are:

President: Mrs. Nellie Chang

Vice President: Mrs. Florence Huntington

Secretary-Treasurer: Mr. Charley Preston

Board Member: Miss Emma Look

Mr. Karl Miller, managing pharmacist at Longs Drugs, Ala Moana Shopping Center, won the Hawaii Pharmaceutical Association Award as "Pharmacist of the Year." Karl has devoted many hours of his time and service to the profession of pharmacy in the interest of public health. It was with great pride that the Association honored Karl. Amfac, Inc., Drug Department, represented by Mr. Tom Sugita also presented Karl with a gift.

James McElhaney received the Bowl of Hygieia Award from James Asato of the A. H. Robins Company.

Henry Urashima presented out-going President's Award from the E. R. Squibb Company to Ben Chock and Noel D. Evans.

Incoming president, Ed Ehlke, received the McKesson Award from Mr. Robert Denman, general manager of McKesson & Robbins—Hawaii.

Richard Hori, chairman of the scholarship committee presented scholarships to:

Sandra Kau, *College of the Pacific*; Diane Louise DeForest, Yvonne Sur, *University of Washington*; Jana Ellen Hong, *University of Southern California*; Calvin Saito, *University of Southern California*.



Henry Urashima, E. R. Squibb Co., presents out-going president award to Ben Chock and Noel D. Evans.



"Pharmacist of the Year" Karl Miller receives plaque from Noel Evans, out-going President of the Hawaii Pharmaceutical Association.

Outgoing President's Message

It was a privilege to serve as President of the Hawaii Pharmaceutical Association, and I wish to thank all the active and associate members that helped the association progress over the past year. We placed special emphasis on several areas: Continuing Education, Venereal Disease Awareness and Prevention, Drug Abuse and Legislation. Through the active participation of many of our members and the leadership of the committee chairmen, these programs were very successful. I cannot thank these people enough.

What I feel is more important is not what was particularly accomplished over the past year, but how it will help our Association reach its goals in the future. Most important is, what are you as an individual member going to do to support your new President and his fellow officers?

Now is the time to lend your support. Through unified efforts the Hawaii Pharmaceutical Association can accomplish goals for the betterment of pharmacy and the individual pharmacist.

Again, I thank you for your support of the association, let's all pay our dues, and push forward with the excellent leadership of your new President, Ed Ehlke.

NOEL D. EVANS

The President's Message

It is with a great deal of pride and humility that I take my position at the helm of the Hawaii Pharmaceutical Association. Pride, to have been chosen from among the many outstanding pharmacists in Hawaii. Humility, because your leaders starting with past president Noel Evans and looking backwards have done an outstanding job and can hold their head high. It is my desire that I can carry on their visions and hopes for the pharmacists in Hawaii.

You can be very proud of your selection of officers and members of the Board of Directors for the year 1972-73 as they represent a cross section of Pharmacy

in Hawaii. For those who were unable to attend our most enjoyable installation banquet, your officers are as follows: James McElhaney, vice president; Mary McMillan, secretary; Loren Wong, treasurer; Board of Directors as follows: Grace Miyawaki, Karl Miller, James Asato, Henry Urashima, Hon Ting Chee, Walter Kam, Earle Sandison, Walter Hiranaka, Nellie Chang, and Noel Evans.

You will be interested to know that in line with our continuing education program, we are most fortunate to have as our first pharmacy seminar participants, three members of the University of Washington School of Pharmacy together with Dean Jack Orr who will act as moderator. This outstanding program will be held at the Shriners Hospital for Crippled Children in Honolulu on the evenings of August 29, 30 and 31, 1972. We are expecting an excellent attendance and all pharmacists and the allied professions are invited to attend. This is but one of the many interesting events scheduled for this year.

Our theme for this year is *involvement*. Unless you become involved in the affairs of our profession and lend your support toward a solution of our many problems, no one can in fairness be critical of the efforts of your leaders. I urge all of you to support Jimmy Asato, chairman of the membership committee. Our legislative committee, headed by Roy Yamauchi and Mike Hong, is already hard at work on matters that affect all pharmacists in Hawaii. Our versatile program committee will offer an interesting change of pace and you can look forward to many enjoyable meetings. Jim McElhaney will again carry the banner for the drug abuse committee and in addition, Jim, together with Lauren Wong, will be the co-editors of our newsletter. This year we have added several new features which will make it the outstanding newsletter of our profession.

My pledge and that of your officers and Board of Directors is to serve you and pharmacy in Hawaii. Let us work together, get involved and success will be ours.

Aloha,
ED EHLKE



James McElhaney receiving "The Bowl of Hygeia" award from James Asato, representative of A. H. Robins.



Ed Ehlke receives In-Coming President's Award from Bob Denman of McKesson and Robbins.

E. House of Delegates action:

The *Advisory Board of Consumers* proposal was referred back to the Council by the House of Delegates. It was felt that the Bureau of Research and Planning should handle community liaison and report to the Council.

ACTION:

It was voted to reject the proposal as presented by Commission on Interprofessional and Public Relations.

Dr. Iaconetti announced that the Bylaws and Parliamentary Committee had been appointed and are working toward an October date for the special House of Delegates meeting.

F. Emergency Medical Services: The following names have been submitted for the Executive Committee of Emergency Medical Services: Herbert Chinn, chairman; Winfred Y. Lee, Thomas Frissell, Wilbur Lummis, and Masaichi Tasaka.

ACTION:

It was voted to approve the nominations as submitted.

Dr. Chinn reviewed the Emergency Medical Services grant which has been submitted through RMP. The Trauma Center portion has been deleted from the original grant but will be resubmitted in another grant. Some decision on the grant is expected within a week.

H. Cancer Research Center: Dr. Chinn reported that a site visit was held recently and there is a good chance that the Hawaii Cancer Research Center will be funded. Dr. Chinn stressed the importance placed on having input from clinicians in cancer research. On the Executive Committee for the proposed center will be four representatives from the University of Hawaii, four from the Hawaii Medical Association and four from the community (DOH, Hospital Association, Cancer Society, etc.). The Executive Committee will appoint the director of the Center. Drs. Chinn and Rose Wong have been appointed to serve on the task force committee.

I. Environmental Health: Dr. Leigh Sakamaki, Chairman of the Environmental Health Committee, reported on three recent conferences he attended relating to the environment. He noted that the HMA Environmental Health Committee is involved in many of the same concerns as committees from other states and felt it was very worthwhile to share experiences. The Council expressed their appreciation to Dr. Sakamaki.

J. Community Health Education: Mr. Thorson reported that a fourth segment of the Emergency Medical Services program concerns community health education. The Trauma Center will probably be included in this grant request.

K. State Joint Practice Committee: The Health Manpower submitted four nominees for the State Joint Practice Committee.

ACTION:

It was voted that the President appoint the members to the State Joint Practice Committee.

COMMUNICATIONS NOT REQUIRING ACTION

Dr. Iaconetti reported that he intends to appoint a committee to meet with Honolulu County Medical Society regarding the transfer of the Foundation on Medical Care to HMA. It was recommended that the HMA Finance Committee also become involved in the negotiations.

COMMUNICATIONS REQUIRING ACTION

A. Publicity Code: A letter from Honolulu County was received suggesting changes in the Publicity Code for Physicians.

ACTION:

It was suggested that a copy of the proposed Honolulu County Code be sent to other county societies and that each county be asked whether or not they intend to submit any changes or recommendations to the present code.

B. Association of Professions: A letter was received from Drs. Cesar B. DeJesus and George Schnack asking for Council approval of Charter and Bylaws for the Hawaii Association of Professions. The letter and attachments had not been circulated prior to the meeting.

ACTION:

It was voted to defer action on the request from the HMA representatives to the Association of Professions until the next Council meeting.

NEW BUSINESS

AMA Resolution No. 31: This resolution will be introduced to the AMA House of Delegates by the California delegation and concerns peer review.

ACTION:

It was voted to instruct the HMA delegate to AMA to support Resolution 31 on the floor of the House and to offer an amendment by adding a third Resolved to read "that after affirmative action on this resolution that this be referred to the appropriate government bodies and other third parties."

Windsor C. Cutting, M.D.: Dr. Cutting, formerly Dean of the University of Hawaii School of Medicine, passed away recently.

ACTION:

It was voted to write to Mrs. Cutting conveying the condolences of the members of the Hawaii Medical Association on the passing of her husband who has contributed so much to the formation of the medical school and the community.

It was further voted to ask HMA members to send their personal contribution to the Windsor C. Cutting Lectureship Fund at the University of Hawaii.

House of Delegates Action: Dr. Reppun asked that the House of Delegates action be summarized and sent to the AMA as well as the HMA membership.

DSS Hearing: A hearing on the use of 1970 RVS as well as other fees for DSS was held in mid-May. The HMA was represented by Mr. Thorson. Dr. Iaconetti reported he has scheduled a meeting with the Director of Social Services for the second week in June and will report back to the Council at the next meeting.

Kaiser-OEO Project: The Community Health Care Committee has filed strong protest against the proposed OEO project for funding itinerant clinics in Kahaluu, Kahuku, and Lahaina. The project does not meet the standards set by HMA and threatens existing facilities.

Request from Dr. Winter: Dr. Lawrence Winter has requested the use of fee survey statistics in preparation of a legal suit. The HMA Fee Survey Committee recommends that the Council approve his request.

ACTION:

It was voted to allow Dr. Winter to use the fee survey statistics.

Future Council Meetings and Officers Meetings: The Council will continue to meet on Friday at 5:00 P.M. on the following dates: August 11, September 22, October 13, November 3, December 15, January 5, February 16, March 9, April 20, and May 11. Officers meetings will be held twice a month at 7:00 A.M. on the Friday morning of the Council meetings as well as the following dates: July 21, August 25, September 8, October 27, November 17, December 1, January 19, February 2, March 23, and April 6.

The meeting adjourned at 9:30 P.M.

R. VARIAN SLOAN, M.D.
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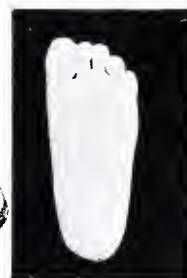
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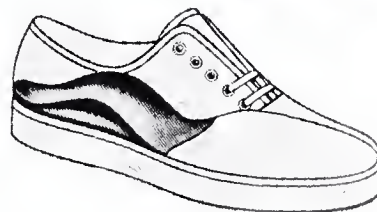


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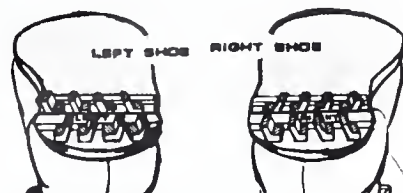
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usually irreversible procedure, surgeons should perhaps mention that vasectomy induces in the body several immunological reactions, the significance of which are, at this time, poorly understood.

Dr. Sandler, of Syracuse, New York (*JAMA*, June 12, 1972) reports that eight of a series of 12 vasectomy patients developed antibodies to antigens which appeared to be identical to the transplantation antigens of their own white cells. These antibodies, if not the same as antibodies to HL-A antigens, are at least cross-reactive with them. Another physician reported that, following vasectomy, one-third of the patients developed antibodies against their own sperm. Several other workers have suggested that thrombophlebitis, prostatovasiculitis, fever, weight loss, and conversion reactivity of serological tests for syphilis may all be consequences of vasectomy.

It would appear that vasectomy is not necessarily, as is so widely believed, a simple and innocuous procedure, but can have widespread consequences whose significance at this time is not well defined or understood. Enthusiastic and unqualified endorsement of this procedure is not warranted at this time.

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Autopsy Room Dialogue:

"Say, this is a real fine specimen." "Yeah, he was taking that exercise program and running 5 miles a day when he died. . . ."

Physicians Speak Up

In a Bob Krauss Special, **Masato Hasegawa** admitted to wearing aloha shirts all the time. He explained, "When a young doctor is trying to prove himself, he wears a suit and tie. After he's become established, he wears aloha shirts." "Yesterday morning, I talked to a group of 'site visitors' from Washington, D.C., to see if we are worth \$1.5 million in research money for the Pacific Regional Medical Program. They all wore coats. . . . I had on my aloha shirt. . . ." He predicted, "You wait and see. . . . This morning, I'll bet they'll be in aloha shirts, too."

Two weeks before his death, Windsor C. Cutting, retired dean of the U. of H. Med School, addressed the last graduating class of the 2-year program and advised the 41 members to "travel light . . . don't bog your life down with unessentials . . . travel with delight . . . you can learn from anyone, even a student . . . don't forget your academic past . . . keep letting stars collide in your minds . . . don't make too much money . . . it will spoil your fun and, unfortunately, it can dull your conscience . . . don't ever again believe the facts you learned in the last six months. . . . What I mean, of course, is don't forego the pleasures of being a lifelong student . . . be something of a nonconformist . . . it stirs up your cholesterol just as well as jogging . . . and don't be afraid to be a starry-eyed idealist . . . the way to face disappointment when those with a short view win is to indulge in some well selected unprintables and a couple of martinis, then get back on the star train with a new telescope." We feel that his epitaph should contain these words from the Advertiser editorial: "He was a sophisticated thinker, but had a folksy, rumpled quality that facilitated rapport. He communicated well with all kinds of people. He was patient, but he knew when not to be patient."

Philip Corboy stopped in Kenya on a world tour and learned that President Jomo Kenyatta has decreed that thieves will hereafter face a mandatory death penalty instead of going to jail for free meals. Philip wrote: "Their proposed methods seem harsh indeed. Compare this to the benign attitude of our Judiciary and Legislature in Hawaii." (re, the Supreme Court decision against capital punishment)

Miscellany

Gleaned from Ed Sherman's column: **Colin McCorriston** tells the story of the 102-year-old woman who came in for a checkup and was pronounced in excellent shape. "Fine, I'll see you next year," she told the doc. "I hope so," the physician replied, "but you certainly seem confident." "I am," she answered. "I looked up the statistics and found that hardly any women die between 102 and 103."

Which reminds of us the joke we heard at the Kuakini Staff party. It seems that a 90-year-old man went to his physician for an annual checkup and was likewise pronounced in excellent shape. "You know, Doc," he said, "I do have one complaint." "What's that," asked the physician. "It's that my sex drive is too high and I would like you to have it lowered." The astonished physician asked, "Just what is too high?" "Well, my sex drive is all in my head these days, and I want you to do something about lowering it."

Colin also says he can remember when it was an apple a day that kept the doctor away—instead of a round of golf.

Conference Humor

A 76 year old woman with transitional cell Ca of the right kidney 4½ years ago and urethral Ca 3 years ago, both treated surgically and then with radiotherapy, had a negative cysto 3 months ago and was now confined for a bony lesion of her pelvis. The question was whether to go for a diagnosis or treat. **Bob Oishi**, with a brusqueness typical of surgeons, recommended "Do another cysto and flip her over and do the biopsy." Chemotherapist **Quint Uy** demurred, "The assumption is pretty good that it is a recurrence." Pathologist **Grant Stemmerman** was dogmatic, "No assumption is 'pretty good' until proven." **Minoru Kimura** asked, "What would the radiotherapists do?" **Quint Uy**, facetiously: "They would irradiate anyway." Moderator **Noboru Oishi** noting the strange quiet from both radiotherapists **Carl Boyer** and **Ed Quinlan**, complained, "The radiologists will not cooperate."

A patient with long standing hypertension and a history of CVA was being worked up as a case of low-renin essential hypertension, its salient feature being a low incidence of CVA; and myocardial infarctions.

Dave Andrews raised the question, "If the urinary aldosterone was elevated, why is it now primary aldosteronism?" The resident smiled weakly, "It primarily involves a little manipulation on our part." **Judy Ramseyer** quipped, "Called *fudging*." Medical director **Jim Orbison** arbitrated, "I guess it involves differentiating between low-renin aldosteronism and high-renin aldosteronism."

At a Kuakini Oncology conference, a 76-year-old Japanese man with adequate acid levels was found to have Ca of the stomach at surgery. Moderator **Quint Uy**: "The acid does not correlate (referring to the association of gastric Ca with achlorhydria). **Grant Stemmerman** stated categorically, "Unfortunately most of the concepts on stomach cancer come from the U.S., where little is known. 80% of our gastric Ca comes from non-acid-forming areas of the stomach. If 5% comes the acid-producing fundus, we are lucky." So as it happens, the very next case on the agenda was a 67-year-old Japanese woman with extensive inoperable Ca of the acid-forming gastric fundus. **Quint Uy** smirked: "Looks like we have a 50% incidence today." Touché!

At Queen's, **Eugene Furth**, visiting professor of medicine from Albany, was introduced for his final lecture, on growth hormones, by medical director **Jim Orbison**, who remarked, "He will discuss the long and short of it." Concluding a most informative series of endocrinology lectures, Eugene with typical wit commented, "I feel like this is the last day of the road show. . . ."

A 82-year-old Japanese man was first treated for prostatic Ca with TUR and estrogen Rx 2 years ago, then he had a subtotal gastrectomy and an exploratory for gastric Ca in May this year. On this admission, necessitated by postprandial emesis, esophagoscopy and biopsy showed a stenotic upper-esophageal malignancy. For a starter, Moderator **Noboru Oishi** turned to pathologist **Grant Stemmerman**: "Grant?" Stemmy: "Two standard cancers." Noboru: "No relation?" Stemmy: "No." Tripler radiologist: "The results have certainly improved with endoscopy and early detection. . . . It's like the situation with Ca in situ of the cervix many years ago."

Stemmy agreed: "Anyone getting a GI series should have endoscopy. No question about it." Radiologist **Ed Quinlan** commented: "Not according to David Hume. . . . He would just as soon have all endoscopists thrown out the window and start with good GI series." **Quint Uy** offered weakly: How about Mithramycin for the bone pain. . . . We can try. . . . Surgeon **Roy Tanouye** squelched this suggestion with: "We can try, but with 2 Ca's, we should keep him comfortable and not try everything. . . ."

continued page 348

INFIRMITAS PECUNIAE?

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Signs and Symptoms

Cure for insomniacs: Lie down at the edge of the bed. . . . You're sure to fall off. If you find kissing a pain in the neck, you may be dating a vampire . . . by **Doug Murray**. . . . A bishop in Denver is credited with this one: a black nun and a white nun went for a walk in the city park after vespers and were attacked by a black man and a white man, respectively. The white nun, seeing resistance was useless, resigned herself to her fate and just uttered a little prayer—"Father, forgive him, for he knoweth not what he doeth." There was a small pause, and then from the direction of the black nun came a response: "*Mine* do!"

Life in These Parts

Bulletin board on Makai III: "Read and Know for Doctors." Recently we read, "Happiness is when doctors leave us." We felt a bit slighted until we made out the word "Smiling" deliberately camouflaged in another color. . . .

Golfer **Masaru Koike** was rushing to make his starting time at MidPac CC one bright June Thursday afternoon when a squad car stopped him on the Nuuanu side of Pali Hwy. As the officer walked toward him with ticket book poised, Masaru resignedly pulled out his license. The officer looked in the back of his station wagon and noticed the golf clubs and cart. . . . He smiled understandingly and motioned him on without even a reprimand. Masaru says, "The cop must have been a golfer too."

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We noticed the lengthening tresses on mod dresser **Mel Kaneshiro** and offered to contribute to a barber kitty. Several days later, Mel stopped us in the corridor to show us his new hair cut and explained, "Shucks, I just wanted to start my own religion. . . ."

One of the most prolific writers, retired physician, scholar, and traveller extraordinary **Kazuo Miyamoto**, recently returned from a 2-month trip to South America. Kazuo has finished his travelogue on Buddhist India, and another story on Camp McCoy, and is working on yet another project on Japanese pirates (WAKO). His formula for all this energy is simple; "I have the urge," he says. . . .

Claude Caver told this one: A woman tourist was on a sightseeing tour of the islands. When the bus stopped at the relics of some old Hawaiian stone phallic symbols, she asked the guide, "What's that?" The educated guide explained, "That's a phallic symbol." The tourist sighed with relief, "Thank goodness. I'd hate to tell you what it looks like."

Hawaiian love? **George Suzuki** had a woman patient, severely beaten by her husband, in ICU. The conscientious new nurse kept insisting that he had to report this case of foreplay to the police. . . .

We received a frantic call on the tennis courts one late afternoon. An elderly woman patient who had suffered a Bell's palsy several days earlier mumbled something about a discharge and wanted to know what to do. . . . We had prescribed Tearisol (a methylcellulose product) for her afflicted eye with instructions to instill at least 4 times a day. We asked her to continue the drops and reassured her. . . . But somehow she seemed confused. . . . Finally the daughter-in-law who had been listening interrupted the dialogue to explain that she was having a vaginal discharge. . . . Oh! Well then, in that case. . . .

We listened to Phyllis Hashimoto, our efficient and personable secretary at HMA, explain sweetly to a caller,

"No sir, this is not HMSA. This is HMA. . . . We are two separate companies." We had never heard of the medical association being referred to as a company, but technically she is right of course, and this eliminates a lengthy explanation on the differences between the two organizations. . . .

When the Hawaii County Council proposed introducing axis deer to the island, one of the opponents, **DeWitt Smith** protested that "high fences may have to be built to prevent the deer from destroying vegetation" and facetiously predicted that "wolves and boa constrictors may have to be introduced to keep an ecological balance."

In June, Hawaii Air National Guard Colonel **Claude Caver** collected and sent more than 800 pounds of medical supplies to Western Samoa. Since 1967 when Baha'i in Samoa first wrote him asking for medical supplies, Claude has collected and sent more than 10 tons of medical supplies, donated by doctors, hospitals, clinics, supply houses, and the medical association.

Item gleaned from the column, "Hawaiian Happenings": "Dr. **Mel Kaneshiro**, former Roosevelt football star, is practicing internal medicine at Kalihi Medical Center."

For what it is worth, a Helen Yast, Director of the Division of Library Services of the American Hospital Association, wrote: "If you wish to inform your readers that the HAWAII MEDICAL JOURNAL is indexed in the Hospital Literature Index, we believe you will be doing them a real service."

A 3-month ETV survey based on 408 households surveyed showed that our HMA's "Medically Speaking" program was exceptionally popular and placed 5th, only behind Sesame Street, Pau Hana Years, Masterpiece Theatre, and Julia Child. As you recall, we were rather unceremoniously dumped by ETV earlier this year to be replaced by the vets and lawyers. We are grateful to KGMB's Cec Heftel, who offered us a Sunday afternoon

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program, now successful as "HMA Hotline" and with more than double the viewing audience. . . .

Breakfast hints: **Walt Quisenberry**, State Dept. of Health director, has peanut butter for breakfast. "It's good on toast sometimes, but I like just eating it on a spoon. . . . Peanut butter contains polyunsaturated oils and is a good energy food because the sugar is digested over a longer period of time than with most sweet substances. Peanut butter gives me energy over a prolonged period of time." Walt limits himself to four eggs a week because of their cholesterol and on special occasions, prepares dropped eggs on lamb chops, a breakfast of gourmets. . . .

Visiting Physicians

Harold Israel, clinical professor of medicine at Jefferson Medical College, speaking at the HMA sessions, gave us a dubious distinction: "Hawaii has not only more asthma, but a more severe type of asthma, than in the country as a whole." Harold feels that it could be molds or fungi or air pollution—despite all the sunshine. "I don't believe that it's simply due to allergy." On the treatment of asthma, he states, "There's an unfortunate amount of fear regarding steroid drugs. In fact, the steroids are the only effective medication for this type of nonallergic adult asthma. These are perfectly safe in small doses and can be tolerated for years and years. . . . Bad consequences with small doses are very remote."

Eugene Furth from Albany, a bespectacled, stout, witty story-teller, kept us spellbound for two weeks as visiting professor of medicine at Queen's. On his first day, sporting a first and second degree sunburn, he said, "As you can see I have availed myself of your solar erythema. . . . If I say something you don't understand, please stop me because I wouldn't know if you. . . ."

continued page 352

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Herein are a few Furthisms:

re, the role of cyclic AMP in hormone action: ACTH, glucagon, vasopressors, and TSH play a role in the formation and destruction of cyclic AMP. . . . Hormones have the capacity for turning on protein synthesis in the cell. . . . Cyclic AMP is an intracellular mediator and is affected by certain drugs, eg, tolbutamide and chloropropamide. . . .

re, treatment of Graves' Disease: "Radioiodine followup studies are a potpourri of somewhat biased data."

re, statistics on surgery and antithyroid drugs: "Figures do not lie, but liars do figure." "The Mayo Clinic keeps two sets of figures, one for the senior staff and one for the junior staff." "Carbimazole has the lowest toxic reactions of all antithyroid drugs and is used in all parts of the world except the US."

"If clinically hyperthyroid and all tests are normal, consider pheochromocytoma." "Inderal is the treatment of choice in thyroid storm. You can give astronomical quantities without side effects."

re, radioiodine therapy: "There has been no increased incidence of thyroid cancer. . . . The contraindications are pregnancy, lactating mother and patients on anticoagulants. . . . We (on the east coast) treat all patients over age 16 while the west coast insists on antithyroid drugs."

re, goiter: Goiter is an ubiquitous and ancient disorder. Two catch 22's on the treatment of endemic goiter are the socioeconomic factor and hyperthyroidism precipitated by iodine in iodine-deficient areas. . . .

re, osteoporosis: "There is no good treatment. We can only prevent and stop aging. Everything tried works transiently. . . . Give adequate Vit D and calcium and keep everybody moving."

In reviewing a case of hypokalemic alkalosis with hyponatremia, probably secondary to thiazides, he warned, "With old people, don't do things in a hurry."

Physicians in Print

Our editor, **Harry Arnold, Jr.** has a hilarious article in the April issue of Honolulu entitled, "Loose Love Can Be Lousy" or more specifically, "The Sexual Revolution has Brought Back Good Times for Phthirius Pubis." Herein are a few excerpts: "While they are on human skin, they live a better life than that of the proverbial Riley, lolling at their ease in a pleasant climate, without a care in the world, an inexhaustible source of their favorite food lying beneath their feet and waiting to be taken. . . ." "Moreover, lice were not an unmixed curse, since they helped keep sleeping scholars awake at night! . . ." "Oh, an occasional venturesome (and lucky) pregnant female louse may linger on a toilet seat or theater chair arm before boarding the next occupant of it, or sojourn a few days in a coat or trouser seam before a new owner puts the garment on. But most such switches take place during body contact, and in the case of Phthirius pubis, the familiar 'crab,' such contact is most apt to take place in a haymow or on a beach or in a bed—now that the rumble seat is gone. . . ." "So, if the sexual revolution hadn't been invented by the 'Now' generation, it might have been a plot fomented by Phthirius pubis to improve his mobility. . . ." "This return to the life style of a century or two ago has surely made life easier for the world's louse population. . . ." Harry concludes with: "It is not helpful, however to tell a patient who says 'I itch like I did when I had crabs'—as one naive internist of my acquaintance [**Nami Kominami**] once did—'In that case, you'd better not eat them any more.'"

Sportsmen

The 2nd Annual Kuakini Golf Tournament (which some feel should be renamed the "**Naomitsu Tajima**")
continued page 355

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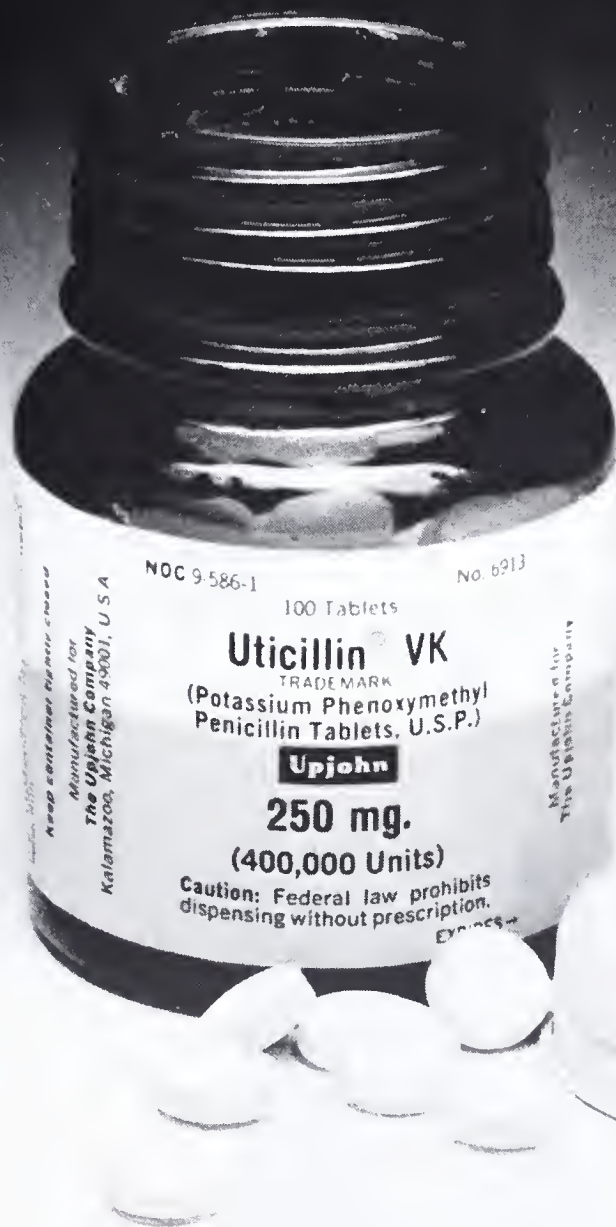
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Notes and News *continued from 352*

Tournament) was held on June 23 at Mid Pac CC with a field of 36. Like the real trouper that he is, Naomitsu won it for the 2nd consecutive year with a net 70 even with a creditable handicap chop from last year. Generous Naomitsu, grinning from ear to ear, again bought champagne for everyone with his jackpot win. We fear **Dick Sakimoto's** Perpetual Trophy may be forced into an early retirement if Naomitsu wins next year again. **Mike Okiihiro**, whose game gelled enough, shot a net 71 for a tie at 3rd place, and consistent winner **Frank Fukunaga** was 4th with a net 72. At net 73's were **Roy Iritani**, **Ike Nadamoto** and **Tom Oshiro**. Both high gross and high net honors went to genial **Bill Ito** who shot 108. It just wasn't his day. . . .

The prestigious 11th Annual Harrah's Tahoe Invitational Golf Tournament was held in June with Hawaii represented by a motley crew of **Ed Emura**, **Richard Lam**, **Ike Nadamoto**, **Dick Omura** and **Paul Tamura**. **Coolidge Wakai** represented Hawaii last year and placed 1st and 2nd on two separate days, as we recall. We doubt this year's group did as well. . . .

In the 6th annual Kokua Golf Klassic at the Royal Kaanapali course, after 36 holes and with one round to go, the team of **Al Ho**, **Wini Lee** and partner tied with **Kiku Kuramoto** and his two partners at 119. **Neal Winn**, an OCC 17 handicapper shot seven pars and 2 birdies and had a best ball of 58, but his team was in 3rd place tied with **John Morris** and partner at 122. HCMS prexy **Wini Lee** had a string of 5 pars broken with a birdie. . . . We won't embarrass Wini by asking what happened after that. . . .

Gary Glover's Repertoire:

An American asked a Frenchman: "What's the secret of the Frenchman? Why are they so successful with

women?" "We kiss them on the navel." "But Americans do that." "But from the inside?"

A vacationer enroute to Mauna Kea Beach Hotel noticed a brand new hotel which said, "Kuakini Annex with Sauna baths: 50¢ a day." He felt that there had to be a gimmick, but he had nothing to lose. The food was delicious and the accommodations superb. There was golf, tennis and swimming. . . . He stayed 2 weeks and had a lovely time. Came checking out time, he asked for the bill. The clerk started to itemize the bill: "50¢ a day for 2 weeks comes to \$7.00." "Don't know how you do it. . . . The tennis was terrific." "Oh, that's another \$1.00 for 2 weeks. . . . Did you swim?" "Yes." "Well, that's another \$1.00." "How about golf?" "Yes, I played golf and used 3 balls." "Well, that's 75¢ for the golf and \$1,000 a ball." "But, they charge only \$1.35 per ball at the Mauna Kea." "Yeah, but at the Mauna Kea they get you by the rooms."

Hors de Combat

Maui is having troubles. . . . In March, **James Fleming** had his office burgled of \$60 in cash and 2,000 pills of various sorts. In April, *Maui News'* "Scuttle" reported, "One of the most popular places on the island for thieves is Dr. Haling's office, which has, according to our spies, been broken into six times and twice the past month." In June, **K. Izumi** and **Sakae Uehara** had their clinic broken into. Missing were 1,098 Seconals, 3,510 phenobarbitals and 175 Tuinal capsules. . . . (Such careful inventory). In July, the action shifted to Hawaii where **Frank Tabrah** had his office at the Kohala Sugar Company dispensary burgled of \$241 worth of stimulants, depressants, and medications.

Our good friend **Fred Dodge** of Aiea has strong feelings about the Vietnam War. . . . He expresses himself

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in rather unorthodox ways. . . . He has refused to pay the federal tax on his phone bill and half of his Federal income tax (because he estimates that half of his taxes go to support the war) and the government levies his bank account to collect the delinquent taxes. In April, he conjured up yet another gimmick. He collected 5,013 pennies (the amount of 2 years of delinquent taxes and the penalty incurred on his phone bill) and left it in a bag at the Internal Revenue Office. The IRS, however pulled a technicality about not accepting pennies in excess of \$7.00 and refused to accept the pennies which Fred strongly (if wrongly) insists is legal tender. . . .

"Health Department Sick! Sick! Sick!" In July, the State Health Department held a luau and 40 of the 200 persons attending developed a gastrointestinal disorder. . . . A preliminary investigation by one of its investigation officers fingered a white sea crab from Kaneohe Bay which had been served raw. Tsk! tsk! tsk! . . .

When ZPG (Zero Population Growth) advertised a raffling for free vasectomies, the Hawaii Urologic Society was naturally upset. . . . President **James Stewart** was quite explicit: "Our society feels that raffling off a surgical procedure, any surgical procedure, borders on the unethical as well as the immoral. . . . As a Society we feel that the vehicle that they have used in promoting this particular sterilization procedure is certainly in poor taste. . . . We sincerely hope that the ZPG will obtain a more satisfactory mechanism than what they have proposed. Our Society feels that this type of action should not be condoned nor supported."

Daffynitions:

Psychoceramic: "A crackpot" (contributed by Wally Mitchell, UH entomologist).

A banker friend insists sex is similar to a savings account. Both lose interest on withdrawal.

Announcements

"The Effects of Alcohol on the Nervous System" by Maurice Victor MD, Chief of Neurology Service, Cleveland Metropolitan General Hospital and Professor of Neurology, Case Western University School of Medicine, on Saturday, Sept. 9, 1972, 8:00 to 9:30 a.m. in Kam Auditorium at Queen's Medical Center.

POSTGRADUATE COURSE CLINICAL GASTROENTEROLOGY

September 10-16, 1972; Castle Harbour Hotel, Bermuda. For additional information write: Vernon M. Smith, M.D., Director, The American Society for Gastrointestinal Endoscopy, 301 St. Paul Place, Baltimore, Md. 21202.

10TH ANNUAL CANCER CHEMOTHERAPY CONFERENCE

Will be held at the University of Wisconsin, Madison, on September 6-8, 1972, presented by the University of Wisconsin Medical Center. For information contact Dr. G. Ramirez, 714C University Hospitals, Madison, Wisconsin 53706.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION SCIENTIFIC ASSEMBLY

The 57th Annual Scientific Assembly will be held at the Washington-Hilton Hotel, Washington, D.C., November 13-16, 1972. For additional information write: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P. O. Box 5445, Madison, Wisconsin 53705.

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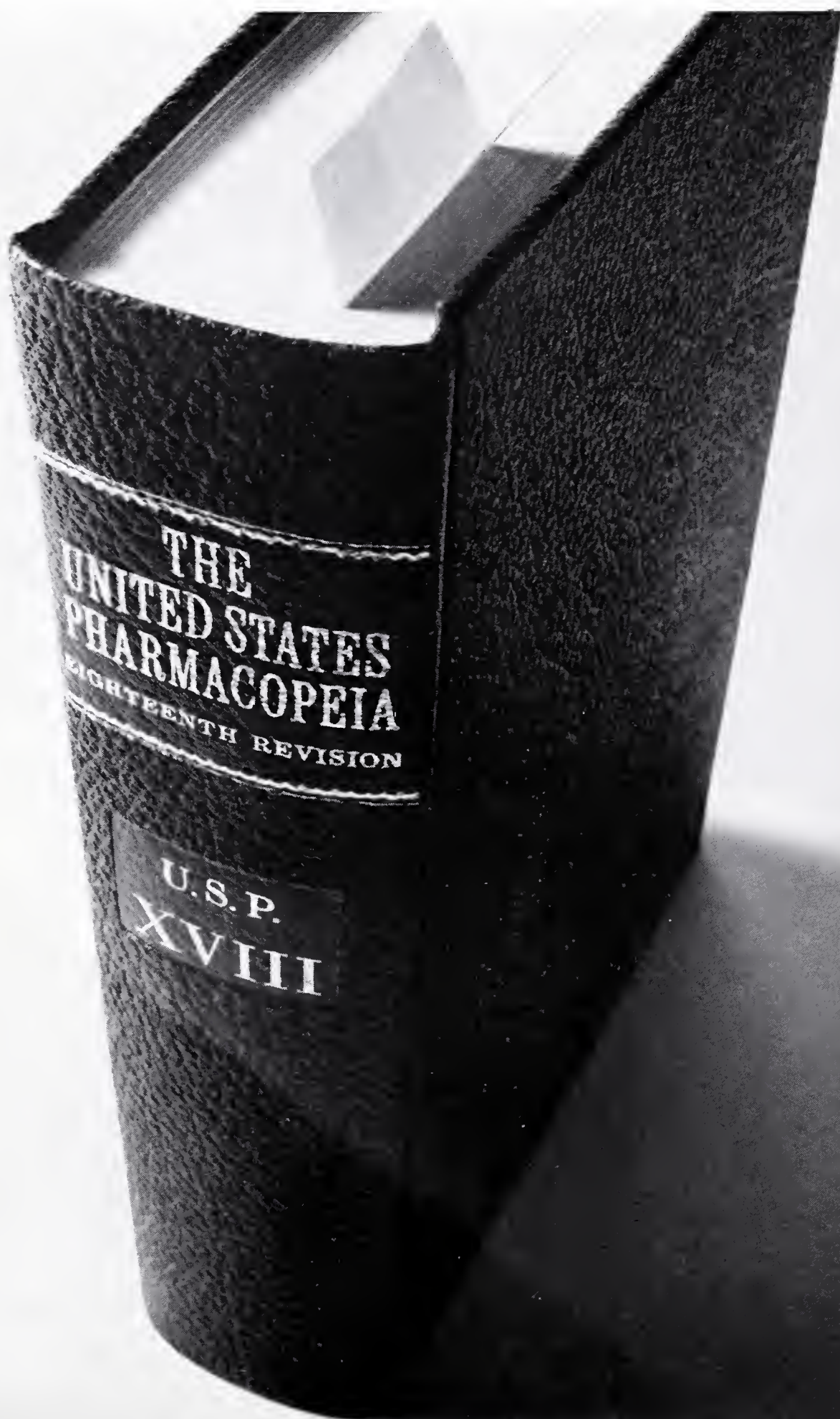
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PREMARIN[®] (Conjugated Estrogens Tablets, U.S.P.)

Indications: PREMARIN provides specific replacement therapy in the management of estrogen deficiency states, notably in the menopause and postmenopause.

Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)

*Menopause (natural or artificial)—*PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.

Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (e.g. atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.

*Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—*1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.

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AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY ANNUAL MEETING

The American Electroencephalographic Society and The American Society of Electroencephalographic Technologists will hold their 1972 Annual Meetings at the Shamrock Hilton Hotel in Houston, Texas October 12th through 14th. For additional information write: Mrs. Margaret H. Henry, Executive Secretary, The American EEG Society, 36391 Maple Grove Rd., Willoughby Hills, Ohio 44094.

AMERICAN COLLEGE OF CHEST PHYSICIANS

Will hold their 38th Annual Scientific Assembly October 23-26, 1972 at the Denver Convention Complex, Denver, Colorado. For additional information write: American College of Chest Physicians, 112 E. Chestnut St., Chicago, Illinois 60611.

AMERICAN COLLEGE OF PHYSICIANS 1972-73 POSTGRADUATE COURSES

These courses are arranged through the cooperation of the directors and the institutions involved. Registration forms and requests for information are to be directed to: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

September 25-29, 1972

BASIC MECHANISMS IN INTERNAL MEDICINE

Medical College of Virginia, Div. of Health Sciences, Richmond, Va.

October 2-4, 1972

CURRENT CONCEPTS IN HEMATOLOGY

University of Pittsburgh School of Medicine, Pittsburgh, Pa.

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October 2-4, 1972

DEVELOPMENTAL BIOLOGY AND PERINATAL MEDICINE

McGill University, Montreal, Que., Can.

October 2-6, 1972

THE NON-MEDICAL USE OF DRUGS: CHALLENGE TO THE PHYSICIAN

New Jersey College of Medicine, Newark, N. J., to be held at the Downtowner Hotel, Newark, N. J.

October 9-11, 1972

ADVANCES IN THERAPEUTICS AND CLINICAL PHARMACOLOGY

Reitz Union, University of Florida, Gainesville, Fla.

October 9-12, 1972

HUMAN REPRODUCTION, POPULATION PROBLEMS AND FERTILITY CONTROL

Harvard Medical School, Boston, Mass.

October 12-14, 1972

RECENT ADVANCES IN INFECTIOUS DISEASES

A Tribute to Dr. Wesley W. Spink; Mayo Mem. Aud., University of Minnesota, Health Sciences Center, Minneapolis, Minn.

November 6-8, 1972

CURRENT AND FUTURE CONCEPTS IN GASTROENTEROLOGY

Univ. of Arizona College of Medicine, Tucson, Ariz.

November 8-10, 1972

INTERNAL MEDICINE GRAND ROUNDS

Mayo Clinic, Rochester, Minn.

November 15-17, 1972

IN-VITRO STUDIES IN NUCLEAR MEDICINE

The Johns Hopkins Medical Institution, Baltimore, Md.

December 4-8, 1972

ADVANCES IN DIAGNOSIS AND TREATMENT IN CLINICAL MEDICINE

Disneyland Hotel, Anaheim, Calif.; Co-sponsored by UCLA School of Medicine, Dept. of Internal Medicine, Los Angeles, Calif., with affiliated hospitals—Harbor General Hosp., Torrance, Calif., St. Mary's Long Beach Hospital, Long Beach, Calif.

January 8-10, 1973

THREE DAYS OF LIVER DISEASE

Woodruff Medical Center of Emory University, Atlanta, Ga., to be held at Royal Coach Motel, Atlanta, Ga.

February 8-10, 1973

RECENT ADVANCES IN THE IMMUNOPROPHYLAXIS AND CHEMOTHERAPY OF INFECTIOUS DISEASES

University of Arizona College of Medicine, Tucson, Ariz.

February 26-March 2, 1973

CLINICAL GASTROENTEROLOGY

University of Michigan Medical Center, Ann Arbor, Mich.

March 5-8, 1973

PROBLEMS OF INTERNATIONAL HEALTH

Co-sponsored by the Naval Department, to be held at LeBaron Hotel, San Diego, Calif.

March 5-8, 1973

MODERN NEUROLOGICAL DIAGNOSIS AND THERAPY

University of Miami School of Medicine, Miami, Fla., to be held at the Eden Roc Hotel, Miami, Fla.

March 12-16, 1973

INFECTIOUS DISEASES

University of Maryland School of Medicine, Baltimore, Md.

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March 14-16, 1973

CLINICAL PHARMACOLOGY: RATIONAL BASIS OF THERAPEUTICS

Univ. of California School of Medicine, San Francisco, Calif.

March 19-23, 1973

FOUR AND ONE-HALF DAYS OF INTERNAL MEDICINE: WHAT'S NEW?

University of Alabama School of Medicine, Birmingham, Ala.

March 22-24, 1973

CLINICAL RECOGNITION AND MANAGEMENT OF HEART DISEASE—1973

University of Arizona Medical Center, Tucson, Ariz.

March 26-30, 1973

CARDIOLOGY—1973—TOPICS OF CURRENT INTEREST

Mount Sinai School of Medicine, New York, N. Y., to be held at the Americana Hotel, New York, N. Y.

April 4-6, 1973

RECENT ADVANCES IN DIAGNOSIS AND MANAGEMENT OF PULMONARY DISEASE

Virginia Mason Medical Center, Seattle, Wash.

April 24-27, 1973

PULMONARY DISEASE

University of Pennsylvania School of Medicine, Philadelphia, Pa.

April 25-27, 1973

HEPATOBIILIARY DISEASE IN CLINICAL PRACTICE

Co-sponsored by Presbyterian Hospital of Pacific Medical Center and the Department of Gastroenterology, University of California, San Francisco, to be held at the Hilton Hotel in San Francisco, Calif.

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What it means to live and work in Tipton County, Tennessee

**Persons who are white and
over 40 have one chance in four
of having solar keratoses...
which may be premalignant**

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons
over 40 in Tipton County, Tennessee**

Female	159	44
Male	117	66

☐ Persons without solar keratoses ☒ Persons with solar keratoses

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



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Sally's back in sew biz! After an arthritic flare-up.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias,

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including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyleurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis,

epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granuloma, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-G

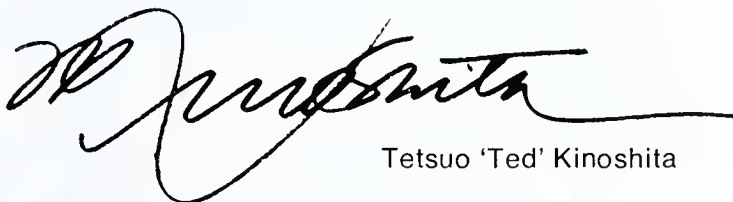
Serious side effects do occur. Select patients carefully (particularly the elderly) and follow the closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

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Letters to the Editor

HAWAII MEDICAL JOURNAL

To the Editor:

Enclosed is a copy of a letter to R. Varian Sloan, M.D., Secretary of the HMA, requesting that you publish Resolution No. 13 which I submitted to the HMA House of Delegates meeting, May, 1972. I would appreciate your also printing my letter to Dr. Sloan as important background information. Thank you.

May I also take this opportunity to comment on Henry Yokoyama's News and Notes, page 356, July-August 1972 issue of the HAWAII MEDICAL JOURNAL.

The IRS *did* accept my 5,013 pennies, which *are* legal tender. But the main point is not pennies—but what an individual can do to resist an undeclared, unjust, immoral and insane war, and thus help stop the killing our government is doing in our name in Southeast Asia? Answer: Refuse to pay for it. One of the best ways is to refuse to pay the 10% Federal phone tax which has been specifically slated for the war.

After World War II, the German people were asked, "Why didn't you do something to stop the killing?" We know more and are in a much better position to do more here and now. Someday our own Nuremburg Principles will be applied to us. He who has eyes to see, ears to hear and a mind to think knows that this is coming. What are we doing to stop our killing?

I invite Henry and all physicians and all citizens to join in resisting death and promoting life—refuse to pay war taxes.

Peace and aloha,

FREDERICK A. DODGE, M.D.

R. Varian Sloan, M.D., Secretary
Hawaii Medical Association

Dear Varian:

On page 330 of the HAWAII MEDICAL JOURNAL, Volume 31, Number 4, July-August, 1972 issue, the following statement was noted concerning the proceedings of the House of Delegates: "The President ruled that Resolution No. 13 was not german [sic] to the purposes and objectives of the HMA and declared the resolution out of order."

One of the purposes and objectives (hopefully the primary one) of all physicians and therefore the Hawaii Medical Association ought to be to save lives and alleviate suffering—in short to promote life. Resolution No. 13 which I introduced is very german to this. Regardless of differences of opinion between myself and the President or other delegates, the Resolution should be published. The membership of the Hawaii Medical Association deserves to know the context of what we voted on for our responsibility as delegates is to them. I request that this be done in the next issue (September-October, 1972) of the HAWAII MEDICAL JOURNAL (copy enclosed).

Sincerely,

FREDERICK A. DODGE, M.D.

RESOLUTION NO. 13

RE: The Southeast Asia tragedy

WHEREAS, It is generally admitted that the United States' military involvement in Southeast Asia has been a mistake; and

WHEREAS, Our leaders, while seemingly appearing to be reducing our destructive forces, are in effect substituting yellow bodies for white ones on the ground, and at the same time escalating attacks from the sea and especially from the air; and

WHEREAS, The automated airwar and electronic battlefield have caused the increasing use of machines and airmen in place of ground troops in the raining down of tremendous forces of death and destruction on the Peoples of Laos, Cambodia and Vietnam; and

WHEREAS, All this results in an increase of American Prisoners of War; and

WHEREAS, The destruction caused by the United States—such as atrocities of which My Lai is but one example, plus the unprecedented airwar—has resulted in millions made refugee, injured, or killed, thus causing decent people all over the world, once admirers of this country, to compare our actions in Southeast Asia to those of abhorred Nazi Germany; now therefore be it

Resolved, That the Hawaii Medical Association go on record as being in favor of immediate cessation of air, sea and land attacks, and supporting the total withdrawal of all U.S. military forces from Southeast Asia as expeditiously as possible; and be it further

Resolved, That copies of this Resolution be sent to the AMA, the Governor of Hawaii and the presiding officers of the Hawaii State Legislature, as well as to each member of the Ninety-Second Congress of the United States of America, and to the President thereof.

Submitted by

FREDERICK A. DODGE, M.D.

Frederick A. Dodge, M.D.
Aiea, Hawaii 96701

Dear Dr. Dodge:

I have reviewed your letter regarding the proceedings of the House of Delegates in the July-August issue of the HAWAII MEDICAL JOURNAL.

Resolutions introduced on an emergency basis must receive the unanimous consent of the House of Delegates before receiving consideration. Resolution No. 13 was ruled out of order, the delegates concurred, and thus it did not become part of the proceedings. For this reason, it was not included in the proceedings of the House as published in the HAWAII MEDICAL JOURNAL.

Sincerely,

WILLIAM E. IACONETTI, M.D.

President, Hawaii Medical Association

vacation in
a vial:
the spasm
reactors
in your practice
deserve



“the Donnatal® Effect”

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

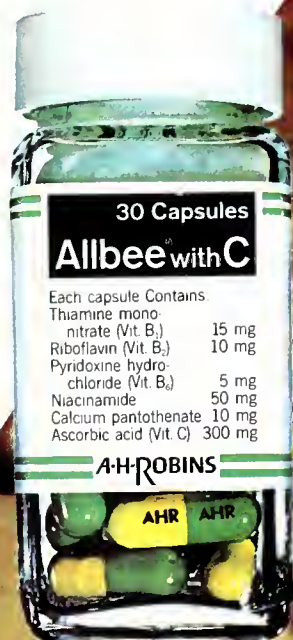
2 ways to provide a daily therapeutic supply of Vitamin C: 15 baked potatoes (skins and all!) or one capsule of Allbee® with C

About 20 mg. Vitamin C in one baked potato (2½" diameter).

To many people the evening meal just isn't complete without potatoes. But your patient would have to eat 15 of them (skins and all!) to get as much Vitamin C as is contained in just one Allbee with C capsule taken daily. A bottle of 30 (month's therapeutic dose) supplies as much ascorbic acid as 450 potatoes, plus full therapeutic amounts of the B-complex vitamins. For the patient who is counting calories, Allbee with C is small potatoes because the B's and C are water soluble. Consider the number of calories in 15 potatoes, not to mention the mountain of butter and sour cream. Allbee with C is available at pharmacies in the handy bottle of 30 and the economy size of 100 on your prescription or recommendation.

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WITH NO SACRIFICE OF THIAZIDE EFFECTIVENESS

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Carolina, P.R. 00630

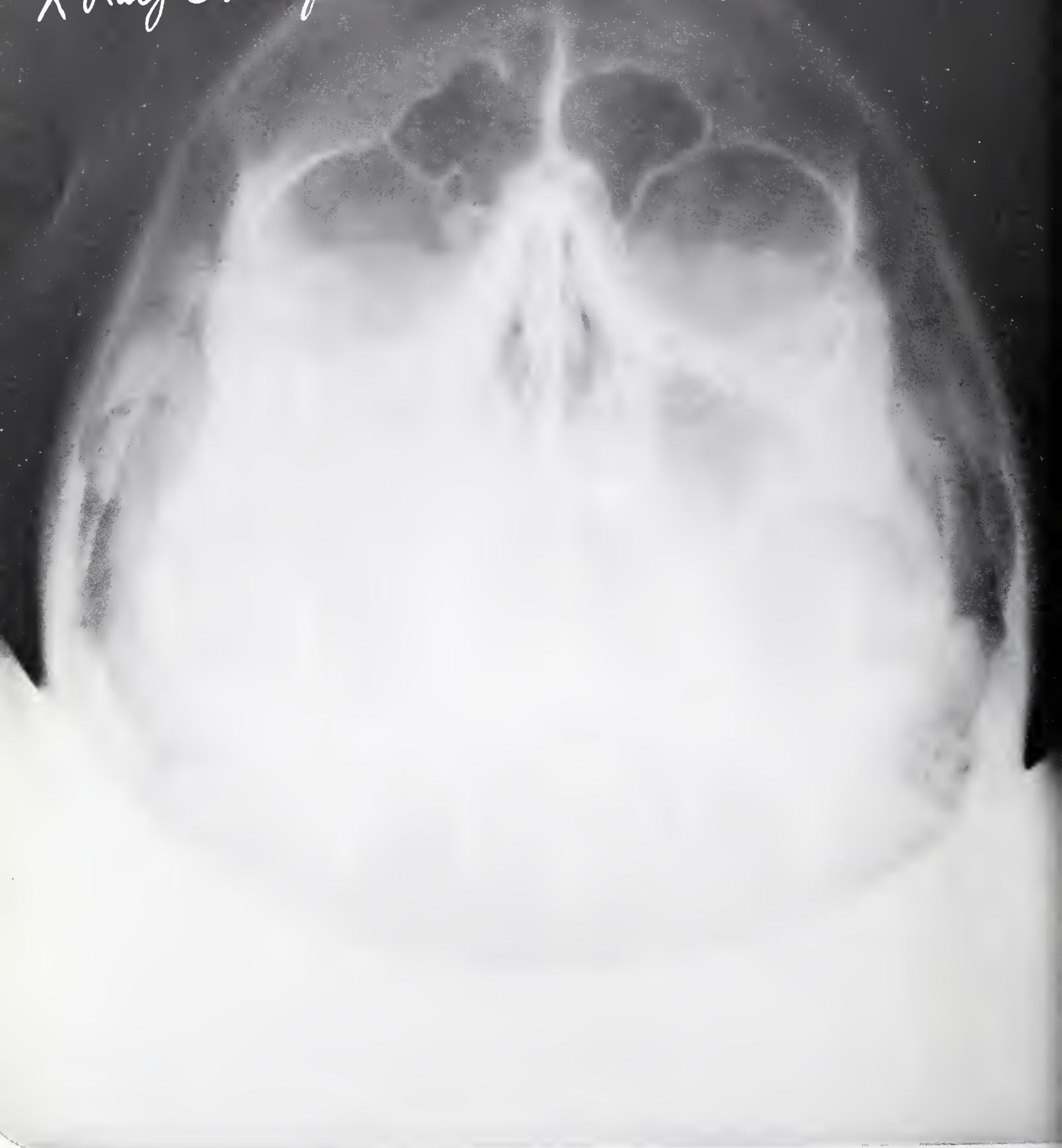
a subsidiary of Smith Kline & French Laboratories

IN EDEMA*—IN HYPERTENSION*

CC: Pain on Rt. side of face

Dx: Acute purulent bacterial Max. Sinusitis

X-Ray Interp: Waters - Clouding of Rt. Max. Sinus



There are many frustrations in treating acute sinusitis.

Cleocin manages most of the bacterial ones.

Inadequate drainage, chronic rhinitis, allergy, exposure to temperature extremes, and other factors can delay recovery from acute sinusitis.

It's helpful to have an antibiotic like Cleocin HCl (clindamycin HCl hydrate, Upjohn) that can take care of most of the gram-positive bacterial problems related to the disease.

As one study* of 52 outpatients showed, acute maxillary sinusitis was associated with staphylococci in 50% of the group, with pneumococci in 25%, and with streptococci and various other organisms (chiefly gram-negative) in the remainder. Significantly, one-half of these staphylococcal infections were resistant to both penicillin and tetracycline (all were sensitive to erythromycin and chloramphenicol). Although not a part of this study, many other clinical and bacteriologic reports¹ have shown that such gram-positive bacteria, which most often are associated with acute sinusitis, are usually susceptible to Cleocin.

Can be taken before, with, or after meals

The total absorption of Cleocin is virtually unaffected by the presence of food in the GI tract.¹ Cleocin thus can be administered as prescribed without interfering with the patient's mealtimes.

Useful in patients hypersensitive to penicillin

Cleocin's chemical structure bears no relationship to penicillin or the cephalosporins. Cleocin therefore may be especially useful in patients with acute sinusitis who report a history of hypersensitivity to these antibiotics. Although hypersensitivity reactions have been uncommon with Cleocin, it should be used cautiously in atopic individuals. Cleocin is not recommended in the lincomycin-sensitive patient.

Please see following page for further prescribing information.



Cleocin[®] HCl © 150 mg capsules
clindamycin HCl hydrate, Upjohn

Side effects: In studies of 1,416 patients involving 92 clinical investigators, side effects were reported in 8.2%.¹ Diarrhea or loose stools were noted in 3% of these cases (one patient with bloody stools). In a few instances, diarrhea lasted several days. A slightly higher incidence of diarrhea or loose stools has been reported by some investigators in subsequent studies.



Toxicity: No irreversible hematologic, renal, dermatologic, or neurologic abnormalities have been reported.¹ Transient leukopenia and eosinophilia have been observed. Elevations of alkaline phosphatase and serum transaminases were observed in a few instances. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

In acute sinusitis and other upper respiratory infections due to susceptible staphylococci, streptococci, and pneumococci

Cleocin[®] HCl

clindamycin HCl hydrate, Upjohn

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin, Upjohn) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Cleocin HCl (clindamycin HCl hydrate) is indicated in infections of the upper and lower respiratory tract, skin and soft tissue, and, adjunctively, dental infections caused by gram-positive organisms which are susceptible to its action, particularly streptococci, pneumococci and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: Patients previously found to be hypersensitive to this compound or to lincomycin.

WARNINGS: Safety for use in pregnancy not established. Not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. Perform periodic liver function tests and blood counts during prolonged therapy. The serum half-life in patients with markedly reduced renal function is approximately twice that in normal patients; hemodialysis and peritoneal dialysis do not effectively remove Cleocin from the blood. Therefore, with severe renal insufficiency, determine serum levels of clindamycin periodically and decrease the dose appropriately. Should overgrowth of nonsusceptible organisms—particularly yeasts—occur, take appropriate clinically indicated measures.

ADVERSE REACTIONS: Generally well tolerated in clinical efficacy studies. Side effects reported in 8.2% of 1,416 patients. Of the total, 6.9% reported gastrointestinal side effects and 1.3% reported other side effects. Diarrhea or loose stools were reported in 3%. *Gastrointestinal:* Symptoms

included abdominal pain, nausea, vomiting and diarrhea or loose stools.

In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. *Hematopoietic:* Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. *Skin and Mucous Membranes:* Skin rash and urticaria have been reported infrequently.

Hypersensitivity Reactions: A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. *Liver:* Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections—150 to 300 mg every 6 hours. Severe infections—300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections—8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections—16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β -hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

SUPPLIED: 150 mg Capsules—Bottles of 16's and 100's. 75 mg Capsules—Bottles of 16's and 100's. Sensitivity Disks—2 μ g. Sensitivity Powder—Vials. For additional product information, see your Upjohn representative or consult package insert. MED B-4-S (LNU-3) JA71-1565

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your estate can receive that constant attention now — by allowing Hawaiian Trust to manage your holdings. We're professionals — the most experienced in Hawaii. We'll collect the income from your assets, reinvest them or pay them to you or to others of your choosing. Later, your estate will go on to benefit your heirs, without being

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What Your AMA Did in 1971-1972

ERNEST B. HOWARD, M.D.

In November 1968, the House noted that the EVP, as the "chief executive officer," had "a unique opportunity to assess the affairs of medicine both internally and in the context of their public impact." It therefore directed the EVP to prepare an annual written report to the House.

In 1969, 1970 and 1971, my reports dealt exclusively with staff affairs. In this 1972 report I have expanded my review in order to present a more comprehensive picture of AMA activities. This report did not appear in the Handbook because I wanted it to be up to the minute. It was completed on Friday, June 16.

THE AMA is a large and complex organization whose wide-ranging, diversified activities are probably unmatched by any voluntary agency in the world. Here is a kalcidoscope of AMA:

1. In one day at the AMA there are 700 long distance telephone calls received. Membership Services gets 137,000 per year. That's 545 per working day.

2. 8,000 to 10,000 pieces of first class mail come in to the AMA every day. Membership Services gets 855 per day or 212,000 per year. This is 6,000,000 pieces of incoming mail every year for the AMA total.

3. Each year we receive 50,000 requests from the general public for help and information, and many thousands more requests for information are received from physicians.

4. In the AMA master listing of physicians, 8,000 changes are made every week to update home and office addresses.

5. Your AMA Library, with quiet efficiency, each month processes and responds to:

- (a) 3,000 research requests
- (b) 700 requests for books
- (c) photocopy requests for approximately 25,000 pages of material
- (d) a steady stream of requests for use of the 4,500 available films

6. The AMA is one of the world's largest publishers and about one third of our budget goes into the paper, printing, and mailing of what is published.

- (a) The *AM News* has a circulation of 20,000,000 newspapers per year
- (b) We produce approximately 1,300 different pamphlets on child care, health education, health tips, sex education, first aid, and many other subjects
- (c) We have mailed 5,000,000 pamphlets on "The Pill" alone
- (d) The magazine *Today's Health* reaches several million readers per month
- (e) "Horizons Unlimited," a brochure on health careers, has been sent in the amount of two million to schools, colleges, and medical societies
- (f) *The Journal of the American Medical Association* distributes 12,000,000 copies per year

7. Throughout the course of the year the AMA sponsors 400 scientific lectures, 400 scientific exhibits and 300 exhibits on drugs.

8. The AMA-ERF Student Loan Program has arranged over \$51,000,000 in loans to over 19,000 medical students, interns, and residents . . . 46,000 loans. We have received and distributed over \$35,000,000 to medical schools in this country.

In addition to these on-going services, some of the special activities during 1972 were:

THE "QUALITY OF LIFE"

The House has properly differentiated between "medical care" and "health," since the latter term embraces many factors other than medical care. As physicians, nevertheless, we have an obligation to provide leadership in stimulating healthful life styles, ecologic improvement, sound nutrition, the elimination of quackery, job fulfillment, worker safety, and many other programs that impinge on health.

AMA's Congress on the Quality of Life conducted in Chicago in March 1972 was structured to provide national impetus to a better quality—and therefore improved health—at the beginning of life. Some 40 national organizations co-sponsored this meeting under AMA leadership. It was an extraordinary success, with over 1,000 participants, and extensive national coverage. One newspaper, the *Chicago Tribune*, published a special five page section on the meeting. The momentum engendered by this first Congress is continuing at this convention, where on June 17 another program on the quality of life for adolescents is being conducted with the active support and guidance of the San Francisco County Medical Society.

MATERNAL AND CHILD HEALTH

AMA's Committee played an important role in promoting the above-mentioned Quality of Life Congress. During the last year it also stimulated the establishment of centralized community or regionalized intensive care centers for infants born at risk, a program which will have a dramatic effect on the USA infant mortality rate once it has been implemented in all key areas.

BLOOD BANKING

Our Committee on Transfusion and Transplantation is conducting a survey of 6,000 blood banks to provide up-to-date information. A current Directory of such facilities will be published by the end of 1972.

HUMAN SEXUALITY

An AMA committee has completed a text on this subject to aid physicians dealing with human sexuality and family counseling. We predict that this text will be a best-seller to the medical profession, other professions, and the public. It will appear later this year.

THE METRIC SYSTEM IN MEDICINE

For over 100 years, the AMA House of Delegates has urged the adoption of the metric system. Because of AMA's recent intensified efforts, medicine today is almost completely "metricated." Following our lead, Congress and academia are now moving toward a metric America.

EVALUATION OF PERMANENT IMPAIRMENT

A fifteen year effort has culminated in the publication of *AMA Guides to the Evaluation of Permanent Impairment*. These guides cover the whole man and represent hundreds of hours of work by dedicated physicians from many specialties. It is the authority in its field.

SCIENTIFIC ASSEMBLY AND POSTGRADUATE EDUCATION

For the first time, here in San Francisco, postgraduate courses are offered at an Annual Convention. All seven courses were sold out a month before the meeting. This is one of many changes in our Scientific Assembly that the Board and Council are considering as efforts are made to improve programs and increase attendance.

NOMENCLATURE

The effort to bring order into the nomenclature morass in which our profession finds itself was more frustrating than ever during the last year.

The AMA publication of *Current Procedural Terminology*, now moving toward its 3rd edition, was the focal point of intense controversy as varied interests maneuvered for control of the basic input. A systematic nomenclature for processing of claims, for peer review, and for effective accumulation, evaluation, and communication of medical information was impeded by the impasse. Accurate identification of the services provided by physicians

was suffering delay because of the clash of differing objectives. The AMA, with the support of most of the medical specialty societies, at times found itself embroiled in a conflict of divergent interests, with the National Association of Blue Shield Plans, the American College of Surgeons, the Commission on Professional and Hospital Activities, and the federal government.

At the time of this report considerable progress was finally being made, differences were being negotiated, and fruition of this phase of the nomenclature effort was expected.

PREScription DRUGS

The first edition of *AMA-Drug Evaluations* was distributed to 230,000 physicians, the most widely circulated single edition of a medical text ever published. A revised, updated 2nd edition will be published in 1973. The Council on Drugs and staff have made a major contribution to the quality of medical care and therapy by this effort.

ALCOHOLISM AND DRUG DEPENDENCE

The Committee on this subject has had an extraordinarily busy year and has participated in practically every constructive action and study program conducted in the nation.

At this meeting you will be considering the Committee's report on marihuana submitted by the Board, which deserves your careful attention.

It can be predicted that alcoholism will receive increasing attention as the dangers of this uncontrolled drug become more apparent.

MEDICAL EDUCATION

The Council, its Committees, and staff are an integral part of America's medical educational effort. Without the daily application of these enormous resources, the production of new physicians and their subsequent graduate and continuing education would experience a sharp setback. No aspect of the education and credentialing of physicians is untouched by the diverse activities of AMA's medical education arm. Among its noteworthy recent contributions are: (1) 41 surveys in the last year of existing, new and developing schools; (2) the "Fifth Pathway Policy," which provides supervised clinical training for U. S. students in foreign medical schools and subsequent entry into the midstream of U. S. medicine; (3) the Annual Education and Licensure issues of *JAMA*, the authoritative references in these two important areas; (4) testimony on behalf of AMA

for increased federal appropriations to support the growing medical educational establishment, and, coincidentally, a new awareness in academia of AMA's significant influence in stimulating legislative actions in their interests; (5) 80 surveys in the last 12 months for accreditation of continuing medical education programs; (6) the encouragement of parallel continuing education programs established in cooperation with AMA by more than 25 state medical associations; (7) the promotion of the California Medical Association's splendid accreditation program for continuing education in community hospitals as a prototype for other state societies; (8) the first national Self-Assessment Resource Center to help guide and assist specialty societies with "in-depth" self-assessment procedures.

EDUCATION OF ALLIED HEALTH PROFESSIONS AND SERVICES

Nineteen medical specialty and allied health associations cooperated with AMA in setting standards and approving educational programs for 18 allied health occupations. Noteworthy during the last year are the establishment of the Subcommittee on Proficiency and Equivalency Examinations to develop guidelines for such examinations, and surveys of nine programs for the training of assistants to primary care physicians.

INTERNATIONAL MEDICINE

(1) The first meeting of the new National Council on International Health, comprising the major national agencies active in this area, was held at AMA Headquarters this year. AMA provided the initial impetus to develop this coordinating activity, and is furnishing staff for the Council.

(2) The recent USA-Russian accord will open up bilateral opportunities for both countries. The Chairman of our Committee on Community Emergency Services leaves for Russia on July 8 to conduct an in-depth survey of the Russian program which has received praise from American observers.

(3) Chinese medicine, including acupuncture for anaesthesia, is the subject of discussions between representatives of China, the USA, and the AMA. You will be hearing much more about that in the near future.

(4) Plans continue for the 4th World Medical Education Conference in Copenhagen this fall, which will bring together experts from many coun-

tries. AMA and the WMA have played leading roles in organizing this Conference.

(5) In Vietnam, AMA continues to provide volunteer practicing physicians for Provincial Hospitals, and, with academia, shares American Medical education expertise to help operate the medical school in Saigon. These are two positive programs that all observers have applauded.

INTERNS AND RESIDENTS

The unique problems and interests of house officers have resulted in recent House of Delegates' actions and intensified AMA staff activity to respond to their needs.

Two mailings have been made to 51,000 interns and residents urging AMA membership and active participation in organized medicine locally. This staff activity is just beginning and will receive continued emphasis.

MEMBERSHIP RECRUITMENT

Another subject of intense preoccupation is our level of dues paying members. In 1971, following the dues increase and the unique situation in New York, where the existing unified membership was declared illegal because of a local statute, AMA lost 12,000 dues paying members. As of June 16, 1972, we are 4,821 members ahead of the comparable figure at this time last year and we are confident that this upward trend will continue for the remainder of the year.

AMA conducted its first membership recruitment campaign this year. 50,000 non-members of AMA who are members locally are being urged to join. This program was carried out in cooperation with 850 medical societies who bill physicians on behalf of AMA. We expect some innovations in billing procedures that should have a salutary effect on membership totals.

PUBLIC AFFAIRS—WASHINGTON, D.C.

The Washington Office staff operation is an integral arm of the public affairs program. During the last year national health insurance legislation, HMO's, PSRO, chiropractic in Medicare, catastrophic expense coverage, medical manpower proposals, cancer and heart research support, and many other controversial issues have kept our Washington staff constantly busy. Due in no small measure to their dedicated efforts, no significant legislation opposed by AMA has passed Congress in this session. Conversely, many bills have become law, due in part to our support and related staff activity.

LEGISLATION

2,300 bills with medical interest have been reviewed by our Council on Legislation and staff. An increasing responsibility of the Legislative Department is the critical review of government regulations which often subtly create new law.

FIELD SERVICE OPERATION

The 12 field offices were realigned into six two-man offices. Service priorities were confined to legislation, political education, and membership growth and retention. A Leadership Consulting Service for medical society executives; state implementation of the Action '72 program; field surveys, by request, of the Texas Medical Association, Baltimore City Medical Society, Mecklenburg County Medical Society, and the Bibb County Medical Society, and close cooperation with AAMSE in the development of six regional conferences were the principal activities this year.

FISCAL CONTROL

The Office of Finance came of age in 1972. Internal auditing procedures and budget control were established throughout the Association. Assembling of expenditures by program, in addition to accountability, facilitated priority planning. Our outside auditing counsel gave enthusiastic endorsement to AMA's internal fiscal controls, an attitude sharply different from the same auditor's reports prior to 1969. At a time of rising expenses, this firm fiscal control assures our dues-paying members they receive maximum value for their money.

CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

This AMA Center has now become one of the leading medical socio-economic research and development activities in the U. S. Here are a few selected items from an extensive program: (1) Staff support is provided our representatives on the Committee on the Health Services Industry; (2) the recent poll of AMA members was developed and processed by the Center; (3) over 25 medical societies have received assistance in the design of surveys and the collection of data, and twenty have prepared grant requests with the aid of the Center; (4) eight volumes have been published on the socioeconomics of medical practice; (5) the important research project being conducted with the University of Southern California on the "economies" of different types of medical practice is still in process, and no final conclusions are available yet.

FOUNDATIONS FOR MEDICAL CARE

This challenging new development in medical society guidance of delivery systems, medical care financing, peer review, and a variety of other programs is receiving close attention from the Council on Medical Service and staff. Three representatives to the Board of Directors of the American Association of Foundations for Medical Care have been appointed by the AMA Board of Trustees and close contact is being maintained with the rapidly developing Foundation movement.

UNIFORM CLAIM FORM

Intensive efforts are being continued to develop a single simplified report form for claims reporting. The Committee on Health Care Financing recently completed its third session with insurers and others involved in claims processing and hopes to bring the current phase of negotiations to fruition soon.

RURAL HEALTH

The Council on Rural Health is the focal point of activities to promote the best possible medical care and health in rural America. It is now developing "models" of effective rural medical care delivery systems in Adams and Lincoln Counties in the State of Washington. We are hopeful that these "models" will provide prototypes for other states to follow.

COMMUNITY HEALTH

This AMA activity included: "Guidelines for Community Health Program"; a statement on health planning approved by the House; a summary of community programs based on site visits to 30 different localities; a review of current multi-phasic health testing; promotion of state and local committees on health care of the poor in 25 state societies and 29 local societies; a 28 minute documentary film on the health of migrant workers; a model program for handling airport medical emergency situations; and a book on *Categorization of Hospital Emergency Capabilities* and a *Guide for Program Planning: Emergency Medical Service Technician*.

PRACTICE MANAGEMENT

This AMA project is being expanded. An "audio survey" on medical practice productivity is under way in which randomly selected physicians are given a list of questions to which responses are made on a blank cassette tape which is then mailed to AMA. The results should be useful and will be

available soon. Our first national conference on this subject will be held in April, 1973.

COMMUNICATIONS

This year has brought new and improved communications contact with the public and the profession: (1) The informational program to the public through paid messages has covered over-eating, exercise, the environment, quality of life, Anatomy of a Doctor, and other subjects. 160,000 people have asked for materials from AMA based on these messages. It has been a successful effort but the cost is high. Whether the cost/benefit ratio will permit its continuation is a difficult question that the Board will have to consider when the 1973 budget is decided.

AMA UPDATE

This new monthly publication reaches 14,500 public opinion leaders in and out of government. It has evoked an enthusiastic response and material from its pages is being reprinted in many newspapers and magazines.

RADIO NEWS TELEPHONE SERVICE

Any radio station in the country can now call AMA over a toll-free telephone hook-up and receive a taped interview on health subjects designed to be integrated into a station's local newscasts. An average of 250 calls is received a week. During this convention well over 500 calls will be received.

AWARDS FOR FILMS, ETC.

AMA's public service announcement on venereal disease received the prestigious Golden Phoenix Award of the International Film Festival, and AMA's film produced for the Explorer Scouts, "Tomorrow Isn't Soon Enough," received the U. S. Industrial Film Festival certificate of creative excellence. *Today's Health* received the Arthritis Foundation's Cecil Award for magazine journalism.

AMERICAN MEDICAL NEWS

This publication is exhibiting a remarkable improvement in its coverage, color photography, and writing excellence. Soon it will be joined by the new AMA magazine on socio-economic subjects. An additional highly qualified editor has been added to the staff. He will attend his first AMA House meeting this week.

STAFF

In view of certain comments that have been

made about staff morale, I would be remiss if I did not make the following observations.

It is difficult to assess the "morale" of a staff of 1,000 employees, 300 of whom are in executive-type positions. There are no easy indices that readily document the level of satisfaction or unhappiness. My appraisal—which is necessarily biased—is that both morale and capability are at an optimal level. I invite the Delegates and state society officers at this convention to talk directly to any of the approximately 195 AMA staffers here to serve you and determine for yourselves their "morale." I have no fear of the results. The men and women serving on your staff are there because they want to be. They are there because they believe in the AMA and what it represents in the nation.

Turnover, of course, does occur. Rarely in the last two years, however, has termination of employment reflected dissatisfaction. The principal cause is a better opportunity elsewhere. The second cause of termination is dismissal.

A specific statistic regarding turnover is available and reflects a favorable trend. In 1966 the turnover among all employees was 37.8%. In 1971 the rate had dropped to 25.7%, which is slightly below the national average for business and professional associations.

One characteristic of AMA staff is their recruitment by other organizations. AMA is truly a "university" for the training of qualified personnel. Some of our top people who have left recently and the positions they now hold are: Ray Cotton, formerly Washington Office staff, now a principal assistant to Assistant Secretary of Health, Dr. DuVal; Chuck Lauer, formerly Director of Sales, now a partner in a medical building construction firm; Jerome Siedlecki, formerly in our Department of Environmental, Public and Occupational Health, now in a top position with Standard Oil of Indiana; Mike Silva, formerly of our Communications Division, now Editor, Yearbook, Encyclopedia Britannica; Marshall Crawford, formerly with our Department of Specialty Society Services, leaving July 1 to be Director of Legislation for the NABSP; Dr. John Nunemaker, formerly Director, Department of Graduate Medical Education, now Executive Director, American Board of Medical Specialties.

Over the years AMA staff has provided top leaders in pharmaceutical manufacturing (Joe Stetler, formerly AMA General Counsel); in government (Dick Wilbur, Assistant Secretary of Defense for Health and Environment, on leave from AMA; and Dr. Charles Edwards, FDA

Commissioner, formerly Director, Division of Socio-Economic Activities); in other associations (e.g., Bill McAuliffe, Executive Director, American Land Title Association; Tom Mura, Director of Communications, NABSP, formerly on AMA's staff), and to academia (Dr. Tom Zimmerman, who becomes Dean, School of Associated Medical Sciences, University of Illinois Medical Center, on July 1, and is now Assistant to the Director of AMA's Division of Medical Education; and Dr. Nichols Taylor, formerly with the Division of Medical Education, now President, University of Health Sciences in Chicago). Interestingly enough, many staffers have left AMA and subsequently returned when the opportunity arose. Several who left in recent years want to return, but there are no openings in their fields.

This brief resume of a few selected items could be continued for endless pages. The exciting, vital work of AMA's 80 committees and councils, the Board of Trustees, this House of Delegates and the staff could fill volumes.

My objective in this review of selected current AMA activities is to spotlight and emphasize the vibrant, responsive nature of our contemporary organization.

Every segment of American life that involves health is touched by some AMA program. Is Dr. Welby accurate scientifically in his medical comments? AMA's Physicians Advisory Committee on Television, Radio and Motion Pictures in Hollywood reviews every word of the script and advises the producer. Does a dermatologic residency program need review? AMA staffs and finances the review committee, and all the other specialty review committees at an annual cost of almost \$500,000. What kind of medical care is given to prisoners in our federal and local prisons? AMA and the American Bar Association have joined forces to study the problem and report to the nation. When the Epilepsy Foundation of America wonders what the other national voluntary health agencies are doing and planning, it attends a meeting sponsored by the AMA's Council on Voluntary Health Agencies, composed of the medical directors of 30 voluntary agencies, and reports on that AMA meeting in its national newsletter. Whether it is the accreditation of hospitals, the prevention of automobile injuries, the protection of athletes, the promotion of environmental and occupational health, or whatever, AMA is involved and is productive. It is a record of continuing accomplishment of which the House, the Board, all the Committees, Councils, Commissions, ad hoc groups and every member physician can be proud.

When does a saprophyte become a pathogen?

Virulent *Escherichia coli* From a Mouse

HARRY H. HIGA, Ph.D.,* and GEORGE Q. L. CHING, B.S.,† Honolulu

Escherichia coli, the coliform organism used as index for water pollution, is not generally considered pathogenic, except in the presence of serious depression of body resistance. This report on the organism, isolated from a mouse, shows it may assume a form virulent for normal mammalian life.

THE MICROBE, *Escherichia coli*, is found normally in the intestines of man and other vertebrates. As a natural inhabitant of the intestinal canal, *E. coli* aids in the splitting of carbohydrates.¹ This organism is employed as an index of pollution in the bacteriological analyses of water.^{1, 2} Its abundance in a water supply is strong indication that the water is polluted with fecal matter.

These organisms sometimes are implicated in urinary tract infections.³ When normal host defenses are inadequate, as in early infancy, old age, or in the terminal stages of other diseases, *E. coli* organisms may reach the blood stream and cause sepsis.⁴ Endocarditis and meningitis⁵ may result from systemic invasion. Gastroenteritis⁶ and pneumonia^{7, 8} have been associated with this organism.

The immunological pattern for *Escherichia* is probably as complex as that for *Salmonella*.¹ The immunological subdivision of *Escherichia coli* is made on the basis of O (somatic) antigens, K

(capsular) antigens, and H (flagellar) antigens. At least 137 serological types are known, of which 11 have been correlated with infantile diarrhea. Epidemic diarrhea in infants may be severe and even fatal.^{5, 9}

This report is intended to emphasize that until recently the importance of *E. coli* as an etiological agent in disease has been underestimated⁵ and that rodents, in this case the mouse, may be the vector.

THE MOUSE WAS SICK

A dead pet white mouse was received by the Department of Health laboratory for examination. Previous to death, this mouse had shown symptoms of disease by its loss in appetite and ruffled fur. At postmortem, the lungs were hemorrhagic and congested. The gastro-intestinal tract was distended. However, the liver and spleen appeared normal.

Slide contact smears of the lungs showed numerous gram negative rods (0.5 x 4 microns) which manifested bipolar staining by use of the Wayson reagent. The liver showed relatively few of these bipolar staining rods and the spleen showed no detectable organisms. (Bipolar staining is a characteristic of virulent plague (*Yersinia pestis*) organisms. *Salmonella typhimurium* may stain bipolar when isolated from the reticuloendothelial organs and lungs of the rat.¹⁰)

The bipolar staining rods present in the lungs and liver of the mouse were isolated on blood agar and found to be motile. The identity of these virulent organisms was established as *Escherichia*

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coli by the cultural characteristics given in Table 1. The results are identical to those for the non-virulent *E. coli*.

TABLE 1.—Cultural characteristics of virulent *Escherichia coli*.

GROWTH ON agar	ACTION ON		TEST FOR other substances
	carbohydrate substances	protein substance	
Blood	+ glucose	AG gelatin —	acetyl- methyl- carbinol —
Citrate	— lactose	AG	indole +
EMB	+ sucrose	AG	NO ₃ +
MacConkey	+ maltose	AG	H ₂ S —
	mannitol	AG	KCN —
	salicin	AG	
	triple sugar iron agar	A/AG	oxidase — catalase + urease — phenyl- alanine deaminase — lysine + arginase + ornithinase —

Legend: (+) positive; (—) negative; (AG) acid, gas; (A/AG) acid slant with acid and gas in butt.

The lungs and liver of the dead mouse were ground with a mortar and pestle, using sterile phosphate-buffered saline, pH 7.4, as diluent to a 25% concentration. Two guinea pigs were inoculated intraperitoneally with 1.0 ml and 2.0 ml of the homogenate, respectively. The guinea pig re-

ceiving 2.0 ml died overnight and the other guinea pig survived. The lungs and liver of the dead guinea pig were homogenized in a Waring blender with the aforementioned diluent to a 25% concentration; 0.1 ml was inoculated into 7.0 ml of brain-heart infusion broth (Difco) and incubated at 37° C for 24 hours. When inoculated intraperitoneally into guinea pigs weighing approximately 300 grams, 1.0 ml of this culture resulted in death of the animals in 24 hours.

After three passages in guinea pigs, 0.125 ml of a 24-hour brain-heart infusion broth culture of the passed organisms killed 300 gram guinea pigs in 24 hours. The viable count of the 24-hour brain-heart infusion broth culture of the first and third passage organisms were 88.7 x 10⁹ and 91.0 x 10⁹ organisms per ml, respectively. This gives an approximate eight-fold increase in virulence after three passages.

—HEMOLYTIC FORM IS PATHOGENIC—

The third passage organisms were strongly hemolytic in comparison to the first and second passage organisms. A hemolytic form¹ has been reported to be highly pathogenic.

The 24-hour brain-heart infusion broth culture of the third passage organisms, when inoculated intraperitoneally in 0.125 ml amounts, killed two *Rattus rattus* male rats weighing 105 and 110 grams and two adult experimental white mice weighing 20 and 25 grams in 24 hours.

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Amniotic fluid creatinine levels are a useful though not infallible parameter of fetal maturity.

Creatinine, a Parameter of Fetal Maturity

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The creatinine concentration in amniotic fluid increases in the last trimester of pregnancy and correlates reasonably well with gestational duration, fetal size, and maturity.¹⁻⁶

This report is based on 160 creatinine determinations from 139 intrauterine pregnancies, 81 of them from early in pregnancy.

FOLLOWING AMNIOCENTESIS or amniotic tapping procedures, 10-ml aliquots of larger volumes were placed in amber bottles and brought immediately to the laboratory. After centrifugation, the supernatant was used for creatinine determination, spectrophotometric scanning for O.D. Δ 450 μ , and tests for other biochemical constituents. These included sodium and potassium by flame photometry (International Laboratories flame photometer), calcium, phosphorus, glucose, urea nitrogen, uric acid, cholesterol, total protein, albumin, bilirubin, alkaline phosphatase, lactic acid dehydrogenase, glutamic oxalacetic transaminase by Technicon SMA 12/60 (kindly performed by Straub Clinic Clinical Laboratory under direction of Dr. Laurence McCarthy), and bilirubin by a modified Jendrassik-Grof method (American Monitor Corporation Kit). Smears of the sediment, air dried, were stained for cellular lipids.⁷

The creatinine determination used was a modified Folin-Wu method (American Society of Clinical Pathologists, Proficiency Test Service, March, 1968). During the months of testing covered in this report, the standard deviation on commercial assayed control serum in the 'normal' range (mean value = 1 mg) was from 0.04 to 0.1 mg and in the 'abnormal' range (mean value = 4.9 mg)

from 0.1 to 0.2 mg. Sources of the amniotic fluid samples are enumerated in Table I.

TABLE 1.—Sources of amniotic fluid samples.

Abdominal amniocentesis prior to saline infusion (elective abortion)	76
Amniotic tap from hysterectomy specimen (elective abortion—sterilization)	5
Abdominal amniocentesis	71
Amniotic tap prior to Cesarean Section	6
Amniotic tap prior to vaginal delivery	2
TOTAL	160

All of the abortuses were studied by standard gross pathologic and selected microscopic examination. Aside from autolysis and hypernatremic effects in the saline infusion cases, no other pathologic changes were found.

Medical records of the mothers and infants were reviewed for evidence of gestational or neonatal abnormalities and for birth weight and other measurements and examination results. The cases placed in the abnormal category are classified in Table 2.

TABLE 2.—Abnormal pregnancies.

	NO. OF ABNORMAL- ITIES	NO. OF CASES WITH 1 OR MORE ABNORMAL- ITIES	STILLBORN OR NEONATAL DEATH
Rh immunization	5	5	3
Diabetes mellitus (including gestational diabetes)	11	11	1
Misc. (pre-eclampsia—6, infection—3, chronic renal disease or hypertension—3, polyhydramnios—2, anomalies—2)	17	13	3
	33	29	7

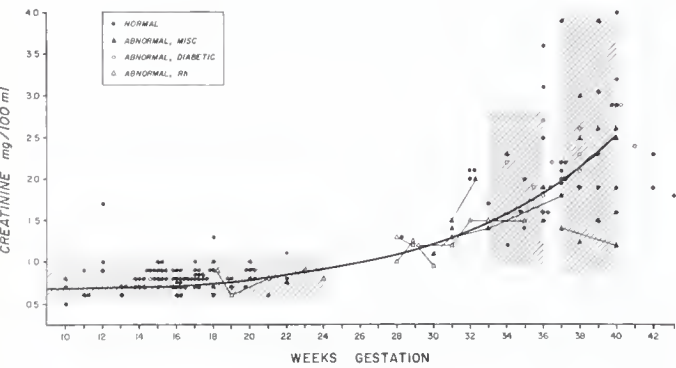
From Kapiolani Maternity and Gynecological Hospital.
Received for publication April 1, 1971.

Estimation of the length of gestation was based on the clinical judgment of the physician and by calculation from the last menstrual period by Naegele's rule. Because a complete maturity assessment was not available in most cases, the birth weight was used as the most objective available criterion of maturity but only in those cases in which birth occurred within one week of amniocentesis.

RESULTS

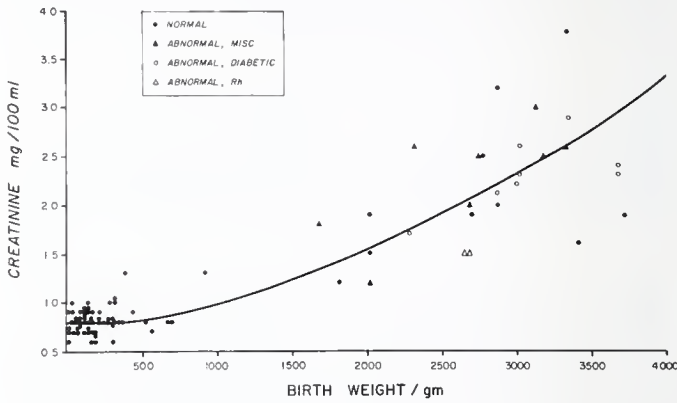
The mean creatinine value at 10-24 weeks gestation was 0.8 mg/100 ml, rising to a mean of 2.4 mg/100 ml at 37 weeks or more (Figure 1).

FIG. 1.—Creatinine vs duration of gestation.



A relatively large overlap in the ± 2 standard deviation ranges between the 33-36 weeks group and the 37+ weeks group was noted (Table 3). The normal and abnormal groups did not appear to have significantly different values. However, there were too few examples of each type of abnormality to fully evaluate significant difference. There was a positive correlation of creatinine values with birth weight (Figure 2). The mean creatinine concentration in the 0-1000 gram birth weight group was 0.8 mg/100 ml, with a standard deviation of 0.11 mg; in the 1000-2500 gram group the mean was 1.7 mg/100 ml, and in the 2500 gram and over group the mean was 2.4 mg/100 ml, with a standard deviation of 0.58 mg.

FIG. 2.—Creatinine vs birth weight. Birth within one week of amniocentesis.



As seen in Table 4, creatinine values of 2 mg/100 ml or above were associated with birth weights of 2500 grams or more in 18 out of 19 cases (95%). This would appear to be a highly significant correlation. However, it should be noted that 8 out of 19 of these cases (42%) were diabetics in whom the birth weight and size would usually be greater than normal and not necessarily directly related to maturity. The need for a more complete examination to assess maturity of these infants is evident but was unfortunately not available in the medical records.

TABLE 4.—Predictability of maturity from amniotic fluid creatinine concentration.

CREATININE IN MG/100 ML	GESTATION (FIGURE 1) 36 WEEKS AND ABOVE	BIRTH WEIGHT (FIGURE 2) 2500 GM AND ABOVE
> 1.9	29/36 (81%)	18/19 (95%)
> 1.8	36/44 (82%)	19/22 (86%)
> 1.7	39/47 (83%)	19/23 (83%)
> 1.6	39/48 (81%)	19/24 (79%)
> 1.5	41/52 (79%)	20/25 (80%)
> 1.4	43/58 (74%)	23/28 (75%)

DISCUSSION

Early in gestation, amniotic fluid is similar to maternal plasma, containing most of the same solutes aside from those of large molecular size.⁸

TABLE 3.—Creatinine versus weeks gestation.

GROUPING IN WEEKS	NO. OF TESTS	MEAN CREATININE IN MG/100 ML	STANDARD DEVIATION	± 2 STANDARD DEVIATION RANGE
10-24	87	0.8	0.1	0.55-1.05
25-32	16	1.4	0.3	0.7-2.1
Normal	3			
Abnormal	13	1.4	0.6	
33-36	19	1.9	0.6	
Normal	14	1.9	0.5	0.97-2.83
Abnormal	5			
37 and over	38	2.4	0.6	
Normal	25	2.4	0.8	0.85-3.95
Abnormal	13	2.3	0.5	

As pregnancy progresses and the volume of amniotic fluid increases from approximately 30 ml at 10 weeks to 700 ml at 36-40 weeks, the constituents change in concentration.^{8, 9, 10} This change is downward for most small molecules and for the osmotic pressure, and upward for urinary nitrogenous wastes and other products of the fetus. Cellular lipid increases in the amniotic fluid sediment after 32-34 weeks.⁷ On spectrophotometric scanning by the method of Liley,¹¹ the optical density difference at 450 μ , representing bilirubinoid pigments, decreases during normal pregnancy as well as in most cases Rh sensitization.^{6, 12, 13} The protein concentration also decreases as pregnancy progresses.¹⁴

The changes in volume and concentration of various constituents result from complex, continuous exchanges between maternal plasma and amniotic fluid across the semipermeable chorionic and amniotic membranes; between the fetus and amniotic fluid by means of fetal excretion, secretion, desquamation, swallowing and gastrointestinal absorption; and between the fetal and maternal blood through the umbilical—placental circulation.⁸ Although many of these exchanges are not well understood in the human, primarily because of the relative unavailability of experimental data, it seems evident that the increase in fetal urinary excretion is primarily responsible for the observed rise in amniotic fluid creatinine concentration. Other nitrogenous wastes such as uric acid and urea nitrogen also increase in the last trimester, but not as consistently as does creatinine.^{2, 12}

The relatively large molecular size of creatinine may prevent prompt equalization of concentration across the semipermeable fetal membranes, thus allowing the amniotic fluid concentration to increase above maternal serum levels. Fetal swallowing of approximately the same volume of hypotonic amniotic fluid as the fetal urinary volume (approximately 500 ml at term) is another relatively unknown facet of this problem.⁸ It is also unclear as to what extent the normal decrease in volume of amniotic fluid near term may have on concentration of various solutes.

The origin of creatinine excreted by the fetus is not known; that is, whether it derives from the maternal blood through the placental circulation and thence to fetal blood, or primarily as a breakdown product of protein metabolism of the fetus. Regardless of the source, the creatinine concentration in amniotic fluid does appear to relate directly to fetal renal function, which in turn is dependent on physiologic maturity. Histologic maturity and presumably physiologically mature glomeruli and tubules are attained by the 36th week when the nephrogenic zone disappears.¹⁵

The most critical organ function related to survival of premature infants is pulmonary. Fortunately, there is a relatively consistent relationship between pulmonary and renal maturity.

The most definitive type of test on which a therapeutic decision to interrupt pregnancy could be most reliably made would be one related more directly to pulmonary maturity, and preferably one in which the risk of hyaline membrane disease could be excluded.

The overlap of creatinine values in gestations before and beyond 37 weeks is relatively great. Thus, conservatism is urged in basing a therapeutic decision on a value in the undeterminate zone of 1.5-1.9 mg/100 ml. A value of 2 mg/100 ml or above can usually be relied upon to correlate with near-term maturity.

Aside from clinical and x-ray evaluation, other parameters of maturity which are often helpful in conjunction with creatinine concentration are cellular lipid in amniotic sediment, O.D. Δ 450 μ , protein, uric acid and certain enzymes. The second part of this study, to be reported later, will deal with some of these tests and will include creatinine in more third trimester normals and abnormals.

The question of the influence of fetal body size per se on creatinine levels needs to be investigated, with more accurate distinction of the premature infant from the low-birth-weight mature or dysmature infant. A complete assessment of maturity based on neonatal examination for flexion of limbs, popliteal angle, 'scarf' sign, moro, suck and rooting reflexes, ear cartilage, breast tissue, skin creases in the foot and rugae of the scrotum, in addition to weight and measurements, is needed to provide more accuracy in defining growth-retarded and growth-enhanced infants from normals.*

Only when these groups are well defined and correlated with amniotic fluid creatinine values, will it be possible to determine whether creatinine is as reliable a maturity indicator for 'abnormal' pregnancies as it appears to be for normal ones.

ACKNOWLEDGMENTS

For assistance in obtaining specimens and helping to assemble data, I wish to thank Drs. Joseph Mitchell, Emi Yamashiro, and the resident staff. For performance of the tests, I wish to thank Mr. Donald Murakami, ASCP MT, Chief Medical Technologist, and staff, Kapiolani Hospital. Assistance is gratefully acknowledged in data collection, statistical analysis and preparation of charts to Miss Linda Bennington, ASCP MT, and

* These maturity assessment criteria have been suggested by Dr. Alistair Philip, Neonatologist, Kapiolani Hospital.

Miss Mary Lou Marsh, second-year medical student, Women's Medical College of Pennsylvania. Graphs were prepared by Miss Susan Young, medical illustrator, and the drafts and manuscript typed by Mrs. John Hamilton.

Support and encouragement from Stanley Saiki, M.D., Chief of Staff, and from the medical staff of Kapiolani Maternity and Gynecological Hospital, as well as from Mr. Richard Davi, Administrator, have been appreciated.

Professor A. W. Liley, National Women's Hospital, Auckland, New Zealand, has kindly reviewed this manuscript. He has commented that he regards "nursery behavior" of the newborn infants as the single most reliable indicator of maturity, regardless of size or duration of pregnancy. He also mentioned that this results have been similar to ours and he stressed the need for a more thorough study of "abnormals" as suggested above.

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The President's Page

The House of Delegates of HMA hopes to meet in a Constitutional Convention on November 4 and 5, 1972. The purpose of the meeting is to take action on the recommendations, regarding bylaw changes, made by the AMA Survey Team that reviewed our Association and its activities. Since the study was done, in August 1971, many manhours have been spent in its review and analysis by a special "Blue Ribbon" committee. The material was broken down into sections and subcommittees were appointed to go into details concerning the merging of administrative staffs, committee structure and functions, public relations, finances, membership development, relationships with other health oriented organizations, etc. Visits were made to each of the neighbor island Medical Societies to obtain their input into the overall body of information. The subcommittees have made their reports to the main committee and all have been consolidated and published in the JOURNAL. During the preparation of all of this material the Council and the Officers have had the opportunity for constant review and consideration of the changes proposed and have had major input into the final recommendations. They have been circulated to the Delegates. The material has been referred to the Bylaws Committee for implementation. The Bylaws Committee will submit its report and recommendations to the House of Delegates.

Some of the changes will reorganize and make the committee structure more flexible and responsive to changing conditions. The merging of administrative activities of the Honolulu County Society and HMA will be given attention. Technical changes are being made in the election processes. Increased representation by the County Societies on the Council is under consideration. The finances of the organization will be reviewed and budget practices may undergo some change. The new Bylaws will permit topics other than scientific to be presented at the annual meeting.

It is hoped that better communications may develop between the HMA and its membership to make the physicians aware of the positive activities of HMA in the fields of Emergency Medical Services, Community Health Planning, the Medical School, Peer Review, Experimental Medical Care Review Organizations, and governmental agencies such as RMP, CHP, and others.

Although we are having an increase in membership, to a large extent because of our increasing vigor and participation in community affairs, more needs to be done to see that physicians coming into Hawaii are given the opportunity to become members. Each County Society should mount a vigorous program to recruit new physicians.

Your understanding of the place that HMA should occupy in your professional life is paramount. With your understanding, medicine can be strong and united, without it our voice has little power.

William E. Leonard MD

Where Do We Go From Here?

In the current furor over the rising cost of medical care, scant attention is paid to the fact it does cost physicians more to provide medical services to patients today than in 1967. In 1967 clients of the Department of Social Services were allowed free choice of physician, in the hope that these patients would be cared for in the mainstream of medicine. What has happened?

The fees agreed to between HMA and DSS in 1967 are still in effect, but as costs increased these original substandard fees are not meeting the cost of providing quality services. Regardless of our wishes, no more will physicians be able to serve DSS clients at the fees we are forced to accept. Surgical specialists involved only in an acute illness may be able to provide services for a while, but generalists, pediatricians, internists, or groups involved in comprehensive care will find it impossible to continue to serve patients at the listed fees.

DSS has stated fees are not negotiable, which puts the profession in a position where an increasing number of physicians are being asked to deliver quality service at less than cost. The Department of Health, at a hearing on August 31, 1972, proposed factors identical to those of the Vocational Rehabilitation Service, which became effective on July 1, 1972. Except for medicine, these are identical with the Medical Assistance Program. At this hearing it was made perfectly

clear that these proposals have nothing to do with the cost of the service. This is a legislative matter.

Unfortunately, citizens commit themselves to far more as politicians than they can deliver as legislators. Mr. Thompson, as director of the Department of Social Services, is given the impossible task of trying to provide millions of dollars worth of services with a grossly inadequate budget.

DSS spokesmen at legislative hearings have stated that 85% of physicians accept present fees. This only means that physicians do not want their fellow citizens to be without care. As the percentage of people covered by Government programs with substandard fees increases, the time is coming when physicians will have to decide whether they will continue to serve these patients. It would appear that the Legislature is our only avenue of relief. There is no law which forces DSS to pay the going rate in the community, which was the only means available to raise fees in Workmen's Compensation cases.

Medical care, as far as I am aware, is the only instance where our Government sets the fees it pays for necessary services with no regard to costs or the going rate for similar services in the community.

Free choice of physicians is a mockery under this system.

JOHN J. LOWREY, M.D.

The Cancer Chemotherapy Project

The Cooperative Cancer Chemotherapy Project of the Hawaii Division of the American Cancer Society has compiled an admirable record of accomplishment in its nearly three years of existence.

Under the chairmanship and direction of Dr. John P. Keenan, a zealous and energetic young oncologist originally from New Zealand, it has piled up:

- Over 7,000 physician-hours of teaching sessions involving perhaps 200 doctors;
- Treatment of 548 patients, whose records have been put on a computer for ultimate detailed analysis; and

- Some 23 inter-island telephone conferences with neighbor island physicians.

Projects under individual directors have been set up at each principal Honolulu hospital: Keenan himself at Queen's Medical Center, Noboru Oishi at Kuakini, Reginald Ho at Straub Clinic, Thomas Lau at St. Francis, Millard Seto at Kapiolani, and Robert Thune at Kaiser.

The medical community in Honolulu, and indeed to a degree in all Hawaii, has been awakened and alerted to the value of cancer chemotherapy and the need to have expert guidance in its ad-

ministration. Physicians now feel free to request such advice, where they formerly felt reluctant to inquire, not feeling sure that such inquiries were appropriate or that they might not be interpreted as an admission of ignorance. Acceptance of chemotherapy as a worthwhile and respectable therapeutic modality is now very good.

In addition, the skills of our chemotherapists have been sharpened by use and by the now abundant interchange of information and experience. At Kuakini Hospital, all cancer cases are

registered and discussed in special conferences at regular intervals.

In the judgment of the Cancer Society's Division Chemotherapy Review Committee, the chairmanship of which has just been turned over by Dr. Sam Allison to General Benjamin Webster, USAF (Ret.), this has been a uniquely effective educational effort on the part of the Society. Dr. Keenan is to be warmly congratulated on the achievement, for which he is certainly primarily responsible.

Toxic Epidermal Necrolysis Revisited

In "Scalded Skin Syndrome Revisited," in the July-August issue of the JOURNAL, Sharon Bintliff, M.D., made the point that this grave dermatosis is now known to be caused by staphylococci of phage group 2, and that the correct treatment is not steroids but methicillin, nafcillin, or an oxacillin, since the organism must be assumed to be penicillin-resistant until and unless proved otherwise.

This overstates the case a little, though it is generally true in infants and children. There is also, however, an adult form of toxic epidermal necrolysis (TEN), in which the cytolysis responsible for the shedding of huge areas of skin occurs in the basal cells, instead of high in the Malpighian or granular layer as in the scalded-skin-syndrome cases.¹ This form of TEN is usually caused by drug allergy; sulfamethizole (Thiosulfil) has been implicated, as have sulfamethoxypyridazine (Kynex, Medice), butazolidin, methotrexate, diphenylhydantoin (Dilantin), and others.

Staphylococcal infection is not primary, and often is not present at all, in these cases. Much less common reported causes are graft-vs-host reaction² and lymphoma.

The proper treatment of these adult-type cases of TEN consists of three things: (1) full doses of steroids, (2) retention of the shedding epidermis in place just as long as it can possibly be retained: it makes the best dressing material possible, and greatly promotes the third vital component of treatment, (3) protection against loss of protein, salt, and water.³ Close attention to electrolyte and water balance is of the greatest importance, of course.

HARRY L. ARNOLD, JR., M.D.

REFERENCES

1. Izumi AK, Griffith RF, Heaton CL: Topical silver nitrate in toxic epidermal necrolysis—Lyell's disease, *Cutis* 6:865, 1970.
2. Peck GL, Herzig GP, Elias PM: TEN in a Patient with Graft-vs-Host Reaction, *Arch. Derm* 105:561, 1972.
3. Malkinson FD, in *Yearbook of Dermatology*, 1972, p. 99, Chicago, Yearbook Publishers, 1972.

Hawaii vs Alaska*

Being on the editorial staff of the JOURNAL is of benefit in various ways. For example, it affords the opportunity to review many of the other state medical journals; this is a privilege not available to the average practicing physician. The state journals have a number of similarities in format, content and editorial thrust. However, each state society has its unique local problems which the resident physicians must understand and resolve.

Two journals which are intriguing to me are ALASKA MEDICINE and the HAWAII MEDICAL JOURNAL. These two youthful states in our Union are widely divergent in background and culture. Yet each offers to its segment of the medical profession a journal of excellence. Many of the sub-

jects discussed are of interest to the midwesterner.

First, let us look at the April 1972 issue of ALASKA MEDICINE. The cover, printed in subtle blues and yellows, depicts an "Alaskan Medical Saga" . . . a montage of "people, places, time and things" in the career of Dr. Milo Fritz who worked among the native people of Alaska. The barren wilderness, the lone polar bear, the sled dogs, a tiny mission, and the montage of medical activity presents a complete story. Through the entire issue there are photographs of Alaskan scenery and life. The scientific presentations address themselves to such universal subjects as drug laws, medical records, and suicide prevention; and, then, there is an essay on "traditional medical cures along the Yukon" by Ginger A. Carroll. Here is an exposé of the powers of the shaman among the Eskimo peoples, as well as an

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* Reprinted from an editorial which appeared in the August issue of the Journal of the Iowa Medical Society.

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over

20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer — as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital*

Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action — involving the doctor, the patient, the American Cancer Society — a partnership for life.

a partnership for life



American Cancer Society 

Hawaii Academy of Family Physicians



... WHERE'S YOUR 201 FILE, BOY?

"Army Medicine" is often a monicker of disparagement. It really shouldn't be. Considering that the term applies to a type of medical practice on a segment of the overall patient population than whom there is none at less risk of serious illness, it is understandable that young medical officers, hot off the griddle of academia and of interesting pathology, get bored and tend to slough off the "worried well" that they mostly see.

It seems passing strange that the push for "new systems of health care" includes the HMO, the acronym for HEW's Health Maintenance Organization, which is actually a prepaid group contract system. "Army Medicine" was—and still is—one of the prototypes for an HMO.

In spite of all that, much that is good has come out of the military, and military medicine in particular. There are a great many of us around who have been processed through that mill! Number one: The efficient way of writing time and date. 0300 Friday 20 Oct 72. No wasted time in punctuation. No chance of error such as interpreting the European 7/8/56, which means Aug. 7, 1956 instead of the American July 8, 1956. No waste of time and effort in writing AM and PM. No confusion between noon and midnight!

Another gem from the military that is long overdue for incorporation into civilian life is the 201 File.

Just think what a saving it would be if the patient presented his physician-of-the-moment a precisely chronological and completely accurate anamnesis!

Currently, hospital in-patient charts on any single patient may well contain the data from several admissions; each chart/admission is stacked onto the previous one. On readmission of that patient, that file is usually immediately available to the attending physician, for perusal. However, he has to wade through repeated accounts of past medical, surgical and obstetrical histories, of the family history, etc., often in illegible handwriting, often contradictory.

In spite of all that, he must write or dictate another anamnesis—if the interval between admissions be greater than six to twelve months.

Except in the rare hospital instance of the "unit record system," which combines in- and out-patient records, this same patient may have been a chronic attender at the same hospital's emergency room, but the record of therapy and aberrations may be unavailable except on devious research.

The medical record of the patient's office visits is the property severally of the various physicians to whom he or she may have gone for medical care. If Dr. Smith wants to know exactly what Dr. Brown diagnosed or prescribed for Mrs. Jones, he must mail an authorized request for release of information and hope that his letter is not simply added to a mountain of unopened mail on Brown's cluttered desk top! Worst of all, in this day and age of the photocopier, Dr. Smith may receive by return mail a blurred and smelly photocopy of the patient's entire record, in Brown's horrible handwriting, including hieroglyphics known only to Brown. What greater intraprofessional insult is there than to shovel this kind of crap at a colleague! "Here, wade through it yourself, old buddy."

As we embark upon the route of peer review, of EMCRO, of quality assessment with Big Brother Government breathing on the napes of our necks, maybe the first thing we should do is to initiate—from birth on—a 201 File, a la the army, on each individual, which *the patient keeps with him* like a passport. "Sorry, Sir, you cannot see the doctor unless you first run home and bring back your 201." It need not contain all the minutiae that usually get into an office record, most of which have no meaning in the long run anyway. And what would you do with the alcoholic, or the couldn't-care-less, always healthy, contemptuous of illness construction worker, or the forgetful elderly, or the psychotic patient? There would be problems, of course, as in any system. But, wouldn't it be neat if the permanently hard-bound file presented to you by the thoughtful patient contained the essential data in typewritten, accurate, and immutable form?

Herein lies the first step towards medically educating the people—to be responsible for their own health!

J. I. FREDERICK REPPUN, M.D.

Blood and Bicycles

The opening of a Bikeway on University Avenue, coupled with an influx of students for the next semester at the University of Hawaii, may well precipitate an outbreak of a recently described syndrome, "banana seat hematuria." First noted by Dr. John LeRoy of the University of Connecticut, the syndrome affects males who ride bicycles equipped with long, narrow, so-called "banana" seats. Vigorous bouncing over uneven roads imparts a repetitive, not unpleasant, massage-like stimulus to the prostate and proximal urethra, resulting in vascular congestion and eventually painless microscopic hematuria. Diagnosis is relatively easy, providing a careful history is taken; treatment, by substituting a wide and well-padded bicycle seat, is uniformly effective.

Bureaucratic Needling

The closing of a recently established acupuncture clinic in New York, together with the seizure of a shipment of Chinese acupuncture needles, indicates that the government is taking a rather unsympathetic look at attempts to commercialize on the current wave of enthusiasm for this ancient therapeutic modality. Perhaps the bureaucrats might be mollified to some extent if they realized that Sir William Osler, one of the revered figures of American medicine, enthusiastically endorsed its use some 60 years ago. Writing in the *New England Journal of Medicine* (August 10, 1972), Dr. Fernandez-Herlihy of Boston relates:

"In the last 15 years, Chinese physicians, encouraged by Mao Tse-Tung, have reintroduced the ancient practice of acupuncture. In recent months, American physicians have witnessed this practice with amazement and growing interest, and magazine articles and books on the subject are proliferating.

"Although the medical uses of acupuncture undoubtedly do credit to Mao's acumen, we can take pride in the fact that a Western physician applied it successfully and advocated its use almost 50 years before the Great Leap Forward of 1958.

"William Osler, as he reported in *The Principles and Practice of Medicine* (seventh edition), found that acupuncture was the most efficient

treatment for lumbago, and he had personal experience with its use. He stated that in many cases, the relief was immediate and extraordinary. He recommended needles 7.6 to 10.2 cm in length, and suggested that a sterilized hatpin would do very nicely. He further recommended blistering for more obstinate cases, and this treatment, I believe, parallels the Oriental practice of moxibustion. Dr. Osler learned acupuncture from 'Ringer,' probably the English physiologist, so that awareness of the procedure seems to orbit westward.

"It is said that the Chinese have yet to publish the results of their research into acupuncture. One would hope that when they do, their bibliography will include a reference to that pioneer North American acupuncturist, William Osler."

Fit as a Fiddle

The word from Washington is that in the future, the Federal Government will channel much of its available Health and Welfare dollars toward the foundation of health maintenance organizations (HMO's). Before joining the rush, one should perhaps stop a moment and try to define just what is meant by health, so that everyone knows exactly what it is that we are going to maintain. The World Health Organization vaguely states that health is not just the absence of disease, but a positive state of physical, mental, and social well-being. However, as any practicing physician will tell you, bounding good health is largely a figment of the fertile imagination of those Madison Avenue types who write television cereal and vitamin commercials. The comments of Dr. Henry Miller perhaps get most closely to the nubbin of the problem:

"I will not labor my own conviction that the normal state of most people is to feel faintly tired, harrassed, and under the weather—and that my clinical observations lead me to believe that an abounding sensation of positive health usually presages either a cardiac infarction or incipient hypomania. The fact remains that the concept of positive health is as popular with some apostles of preventive medicine as with lay journalists. It postulates a state that could apparently be achieved by the careful observation of a set of rules that vary with the writer but which are al-

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ICHD Reports



This may be the Age of Aquarius—the age of love for some, but for the physician it is the age of peer review and self-assessment.

How does our community, our practice, our knowledge measure up? What is the standard by which we may determine our delivery of medical care?

There are the interminable, stereotyped, often useless review committees from tissue to credentials. There is painful Beverly, and now EMCRO. Surgeons, internists and orthopedists have turned to self-assessment tests. Third-party payers and government have their own special forms of scrutiny.

One of the most significant pieces of work, the ICHD Reports, has been performed without a great deal of fanfare. The President's Commission on Heart Disease, Cancer and Stroke Report of 1964 culminated in the establishment of Regional Medical Programs. The Division of RMP negotiated a contract with the American Heart Association to "act as the fiscal agent and to coordinate the efforts of appropriate national professional organizations in the development of *guidelines for the care of patients with cardiovascular disease. These guidelines will indicate the human and material resources necessary to provide optimal care for patients. . . .*"¹

Thirty-four organizations, ranging from the American Heart Association to the American Psychiatric Association and a veritable Who's Who of cardiovascular disease experts, were organized as the Inter-Society Commission for Heart Disease Resources under the chairmanship of Irving S. Wright, with Donald T. Fredrickson as project director.

The first report, appearing in *Circulation*, May, 1970, on the prevention of rheumatic fever and rheumatic heart disease, was a tour de force which has happily been repeated in most of the subsequent reports in all areas of cardiovascular disease.

Here is the standard by which we can examine such specific questions as: How many open-heart surgical teams should Honolulu have? What catheterization capability is needed? Here is the guide by which we can determine if our community has the basic resources needed for prevention and control of cardiovascular disease appropriate for 1972.

This Herculean effort has provided a monumental result. Obviously one may disagree with details, even broad concepts, but the work stands as a reminder to look at ourselves and how we serve our patients and the community.

The significance of these reports is such that the American Heart Association has asked all affiliates and chapters to place special emphasis on them.

Hawaii Heart Association feels that the impact of the reports is so great that no one organization is capable of evaluating and implementing these studies alone. We urge all areas of the medical, business, governmental, and consumer communities to join in this task. Hawaii Heart Association proposes to establish a committee representing all community segments, professional and non-professional, for this purpose. We urge that every one of you make yourselves acquainted with ICHD and give your utmost in cooperation.

ALFRED D. MORRIS, M.D.

President, Hawaii Heart Association

¹ "Inter-Society Commission for Heart Disease Resources Report," Foreword p. vi, *Circulation* 61:5 (May) 1970.

★Shand's Handbook of Orthopaedic Surgery, 8th Ed.

By R. B. Raney, Sr., M.D., H. R. Brashear, Jr., M.D., and A. R. Shand, Jr., M.D., \$15.00, The C. V. Mosby Co., 1971.

IT IS ALWAYS nice to meet an old friend after many years. Now in the eighth edition, *Shand's Handbook of Orthopaedic Surgery* seems far more vital and informative than it did in the second edition, even beyond the advances in the state of the art. Much of the verbosity and a good portion of the old illustrations have been removed and a more incisive, simplified, clear-cut style of writing has replaced them. The majority of the illustrations have been reworked. There are still a few of the old engravings, which give a sense of history and a touch of nostalgia to this book, now in its thirty-fifth year of publication.

Drs. Raney and Brashear have done an excellent job in creating a concise orthopedic textbook which is aimed as well at the general practitioner. A unique feature is the extensive bibliography of orthopedics, chapter by chapter and subject by subject. Their list of general textbooks is also of great value. Other unique features are the line illustrations of bursae about various joints, good quality X-ray reproductions, description of ranges of motion, a whole chapter on amputations, prostheses and braces, and an adequate section on scoliosis, including the Milwaukee brace.

All in all, an excellent book which should continue through many more editions.

ROWLIN L. LICHTER, M.D.

The Human Spine in Health and Disease

By Georg Schmorl, M.D., and Herbert Junghanns, M.D., \$38.00, Grune and Stratton, Inc., 1971.

THIS RECENT revision of a classic monograph is highly recommended to orthopedists, neurosurgeons, and other physicians who deal with the spine. It is probably the most complete clinical text on the spine available. There is a comprehensive coverage of the subject of the spine, including embryology, anatomy, radiology, diseases, and injuries. The illustrations are superb, especially the reproductions of the X-rays and the bibliography is extensive, including ten separate pages devoted to the recent English-language medical literature.

ALBERT CHUN-HOON, M.D.

1972 Drugs of Choice 1973

By Walter Modell, 990 pp., \$21.50, C. V. Mosby Company, 1972.

THIS IS THE eighth edition of a well known, comprehensive, indexed guide to drug selection. As usual over the years, the book has been able to maintain its high standard. The book provides an adequate amount of pertinent pharmacological discussion about the relative merits of the drugs and their adverse reactions. Selected references in the form of supplementary literature should prove very useful to the physician who would like to pursue certain aspects of drug therapy in more details.

★ means highly recommended.

Tables providing a quick reference at a glance, about the adverse reaction of drugs, choice of alternate drugs and selection of antimicrobial agents, etc., should prove very useful. A green paper appendix listing the drugs with generic and trade names, should be helpful to the practicing physicians.

Some selections are a bit too long and all the authorities may not approve some of the advice. However, the book, on the whole, is recommended for every physician and hospital, particularly the Emergency Room library. The well indexed information, with handy tables, should prove very useful, for a guide reference.

B. R. MEHTA, M.D.

★Introduction to Electrocardiography, 2d Ed.

By Thomas M. Blake, 218 pp., \$7.50, Meredith Corporation, 1972.

BOOKS ON electrocardiography are often dull and stereotyped, but this small book is a pleasant surprise. It is a successful blend of clinical cardiology with electrocardiography, which is refreshing to read. Instead of the usual format of teaching pattern-recognition, emphasis is on the understanding of basic electrophysiology and its manifestations in the electrocardiogram. The vectoral concept is often used to explain EKG changes, which is probably the best and simplest way to teach electrocardiography. Many recently introduced terms are found in this book: for instance, sick sinus syndrome, the hemiblocks, trifascicular block, as well as a good discussion on the diagnostic criteria for myocardial ischemia in stress testing. The chapter on electrocardiographic technique should be read by all EKG laboratory personnel and beginners in this field. There is also a complete list of reference for those interested. For \$7.50, medical students should find it a good investment.

SIMON CHANG, M.D.

Clinical Histopathology of the Liver, An Atlas

By Wilhelm Wepler and Egmont Wildhirt, 158 pp., \$25.00, Grune & Stratton, Inc., 1972.

THE INTRODUCTION to this atlas of liver pathology states the purposes of the book and also gives a good general discussion of the problems of interpreting needle biopsy specimens. As is pointed out in the introduction, this is an atlas and not a text book. The photographs, both color and black and white, are good throughout. Each case is accompanied by clinical as well as pathological information. The short discussions at the beginnings of the chapters which introduce the type of lesions to be exemplified, are informative and noteworthy because of personal comments by the authors. The terminology used may be confusing to some since it does not always follow the recently advocated classification. However, any internist or pathologist, reasonably well acquainted with the present concepts of liver diseases, should have little trouble with the authors' terminology. This book is primarily suited to those internists and pathologists with a particular interest in interpretation of needle biopsy specimens. As such it is a good supplement to a liver histopathology library.

ANN B. CATES

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Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

August 11, 1972 — 5:00 P.M.

Mabel Smyth Conference Room

PRESENT

Dr. William E. Iaconetti, presiding; Drs. Herbert Y. H. Chinn, Thomas P. Frissell, R. Varian Sloan, Grover H. Batten, George H. Mills, William W. L. Dang, George Goto, J. I. F. Reppun, Peter Kim, Ed. B. Helms, Sakae Uehara, Winfred Y. Lee, Denis Fu, DeWitt H. Smith, Katok A. Chuang, E. Robert Ballard, Albert C. K. Chun-Hoon, Calvin C. J. Sia, Fred I. Gilbert, Masato M. Hasegawa, Rowlin L. Lichter, Cesar B. DeJesus, George F. Schnack, and Neal Winn.

CALL TO ORDER

The meeting was called to order by President Iaconetti.

MINUTES

The minutes of the June 2, 1972, meeting were approved as circulated.

REPORT OF THE SECRETARY

The report of the Secretary was accepted as presented.

REPORT OF THE TREASURER

The report of the Finance Committee was reviewed by Dr. Batten. He reported that the first payment for indirect costs on the EMCRO project has been received.

ACTION:

It was voted to approve the recommendation of the Finance Committee that income from projects such as EMCRO be deposited in separate accounts of its own, individually accounted for, earmarked for operations as needed, and that any remaining funds be held uncommitted until the project is completed as accumulated surplus.

ACTION:

It was voted to approve guidelines for reimbursement of meeting expenses as follows: (1) Councillors and authorized members of HMA who attend various council meetings, etc. will be reimbursed by HMA for expenses incurred up to a maximum of \$35.00 per day plus airfare. (2) For mainland travel, HMA will pay for appropriate incurred expenses up to a maximum of \$50.00 per day plus Economy Class ("Y") airfare.

Stipend for President's Assistant: The Finance Committee reviewed the request for an increase in the stipend of the President's Assistant and reported (1) that the committee had not been authorized to pay more than \$500 per month, (2) that the grant is not included in the 1972 budget, (3) that the Council will need to resolve this problem. It was further suggested that it might be appropriate to bring this matter before the next session of the House of Delegates to be held in November and suggest that the increase of \$500 to \$1,000 be retroactive to July 1, 1972. It was felt that the Assistant to the President is part of the staff, and as such the Council has the authority to increase the stipend if so recommended by the President to whom she is an assistant. It was also suggested that a job description for this position be completed as soon as possible.

ACTION:

It was voted to increase the stipend of the President's Assistant to \$1,000 retroactive to July 1.

HMA Roster: The Finance Committee is considering the cost involved in printing an addendum to the HMA Roster versus printing a new Roster every year. A recommendation will be made after the information is received.

Hawaii Medical Journal: Dr. Batten reported that the cost of publishing the HAWAII MEDICAL JOURNAL increased as of June 1, 1972. The increase had been anticipated somewhat and subscriptions and advertising rates were increased in January 1972. There has been a drop in national advertising as well as increased postage rates which affect the HMJ as well as other specialty journals. The Finance Committee will continue to explore means of increasing revenue for the Journal.

Dues Refund: At the last Council meeting, action was taken to issue a refund of dues to the family of Dr. Edward Wong. The AMA was contacted and a refund of the AMA portion has been received. The HMA By-laws forbid a refund of dues for any reason. It was suggested that perhaps a gift could be transmitted from HMA through Hawaii County Medical Society. Since a Constitutional Convention will be held in early November the following action was taken:

ACTION:

It was voted to postpone the matter of a dues refund until after the Constitutional Convention.

HMA-HCMS Common Fund: A question was raised as to the status of the Common Fund. Mr. Thorson reported that a time study had just recently been completed and that a report could be made to the next Council meeting.

Election of Finance Committee: Dr. Iaconetti recommended that Dr. Marcelino J. Avecilla be appointed to serve a three-year term on the Finance Committee.

ACTION:

It was voted to accept the nomination of the President and that the President be given the authority to appoint another representative should the need arise.

COMMUNICATIONS NOT REQUIRING ACTION

Press Release: Drs. Iaconetti and Frissell held a press conference on August 3, 1972 to answer any questions regarding the HMA Study on the Quality of Care. The conference was attended by several television stations and newspapers.

Committee to Transfer Foundation to HMA: Dr. Iaconetti announced that he has appointed Dr. George H. Mills as chairman of the HMA's committee to negotiate the transfer of the Hawaii Foundation for Medical Care to HMA. Other committee members are DeWitt H. Smith, Katok Chuang, and J. Mark Sowers. Dr. Lee noted that the appointment of the chairman of this committee is not a unilateral decision, and that Dr. Mills can serve as the chairman of the HMA negotiating team but that Honolulu County will appoint the chairman of their team.

Cosponsorship of Conference: It was announced that the HMA has agreed to cosponsor a conference on "Relationships between State Medical Associations and Voluntary Health Agencies" on Friday, May 4 in San

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Honolulu

The June 6, 1972 meeting was called to order by President Winfred Lee. He then introduced to the membership new members, Drs. Joseph A. Brock and Edwin Dierdorf.

Minutes of the May 2, 1972 membership meeting were approved as read by Dr. William Moore.

Dr. Lee introduced Frank F. Fasi, Mayor, City and County of Honolulu, who was the speaker for the program. Mayor Fasi spoke about problems of the medical services provided by the City with special emphasis on emergency medical services. A question and answer period followed in which the Mayor fielded questions in all areas concerning the City administration.

Dr. Frissell, Chairman of HMA's EMCRO Executive Board, announced that in the next few months, physicians will be receiving postcards asking them to join EMCRO. As this is an HMA project, Dr. Frissell asked that all physicians see fit to join.

Dr. Lee informed the membership of the newly established Peer Review Committee. This committee is being appointed on an ad hoc basis until the committee structure of HCMS is finalized. The concept of peer review is in four areas as follows: 1. Cost (claims review), such as HMSA and other insurance carriers; 2. Utilization, such as hospital UR committees; 3. Quality of care; 4. Ethics, such as business referred to our Medical Practice Committee. One of the objectives of the Peer Review Committee will be to be as objective and as credible as possible.

Dr. Lee did not want to make a full report on the deliberations of the HMA House of Delegates but he did wish to bring to the membership the following significant occurrences at the House of Delegates meeting: 1. A resolution relative to making membership mandatory in the county, state and AMA did not pass; 2. House accepted the report of Committee on Commissions; 3. The transfer of the Foundation for Medical Care was accepted by HMA from HCMS with just compensation and negotiations commencing; 4. House appropriated funds for the HMA to continue its legal action in the Workmen's Compensation issue.

Dr. Lee announced that a HCMS-endorsed group life insurance program will be going into effect this month for HCMS members. The more physician participation the better. This program is of benefit especially to the "older" or "uninsurable" physician.

Dr. Lee announced there would be no membership meetings in July and August. A regular membership

meeting will resume in September. During this time the Board of Governors will be looking into methods of changing our committee structure and/or bylaws. If any members are keenly interested in this area they are welcome to attend meetings of the Board to express their opinions.

There being no further business, the meeting was adjourned at 9:00 P.M.

Maui

The Maui County Medical Society met at Naokee's Steak House on Tuesday, August 15, 1972.

Members present included: Drs. Achong, Briley, Fu, Haling, Iaconetti, Izumi, LaFon, Moran, Morris, Patterson, Peat, Uehara, Underwood and Withers.

The minutes of June 20, 1972 were approved as circulated.

Dr. F. Maag's request to be listed as an inactive member from August 15, 1972 was approved.

The Emergency Medical Service Program was then discussed. A meeting on August 11, 1972 held at Mabel Smyth with Dr. Thomas Chang revealed that the present program included ten weeks of training in Honolulu and that representative trainees from Hawaii and Maui would be considered with per diem and transportation cost being funded from the program.

Dr. Uehara then reported on the Council Meeting of August 11, 1972. He reported that the Constitutional Convention will be held on November 4-5 and that Careers Day will be on October 18, 1972. He also reported on the Kaiser-OEO Grant and the Publicity Code for Physicians which was accepted with substitution of paragraph 7. The Grant request from NIH for the University of Hawaii Medical School did not meet the Council's endorsement. Dr. Uehara was recognized for his efforts with the Council.

Dr. Morris then voiced his objection to the negative endorsement by the Council regarding the NIH Grant request to the University Medical School.

A communication was received from the California Society of Internal Medicine regarding their forthcoming Annual Meeting to be held at the Royal Lahaina on October 4-10, 1972.

Dr. Underwood brought up a point of discussion from the Department of Health's recent letter regarding routine gonococcal smears. It was well taken that nowhere in the letter did it mention that the patient's permission should be obtained nor would the patient's privacy be maintained.

New Members



James A. Dennis, M.D.

87-217 St. Johns Road
Mali, Hawaii 96792

GENERAL PRACTICE

Medical University of South Carolina
—1967

Internship—Medical University
Teaching Hospitals—1967-1968



James A. Dow, M.D.

1163 S. Beretania St., Suite 202
Honolulu, Hawaii 96814

UROLOGY

Kyung-Pook University, Korea—1953
Surgical Internship—U.S. 43rd Army

Korean Hospital—1953-1955

Urology Internship—Bergen Pines
County Hospital, Paramus,
New Jersey—1956

Surgical Residency—St. Elizabeth's
Hospital, Richmond, Va.—1957

Urology Residency—Episcopal
Hospital, Philadelphia, Pa.—
1958-1960

Pathology Residency—Armed Forces
Institute of Pathology,
Washington, D.C.—1961-1964



Clarence Funaki, M.D.

G. N. Wilcox Hospital
Lihue, Kauai 96766

RADIOLOGY

University of Colorado—1965
Internship—Queen's Medical Center

—1965-1966

Residency—University of Colorado
—1968-1971



William H. Montgomery, M.D.

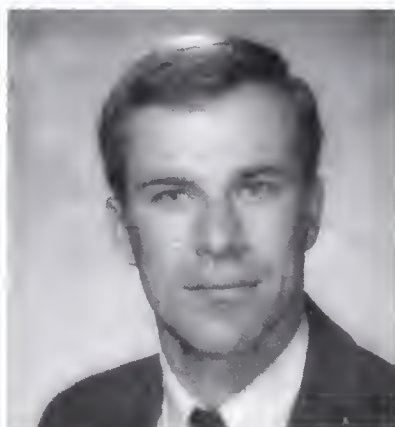
888 South King Street
Honolulu, Hawaii 96813

ANESTHESIA

Ohio State University College of
Medicine—1965

Internship—University of Michigan
Medical Center—1965-1966

Residency—Stanford University
Hospital—1969-1971



Ernest N. Platt, M.D.

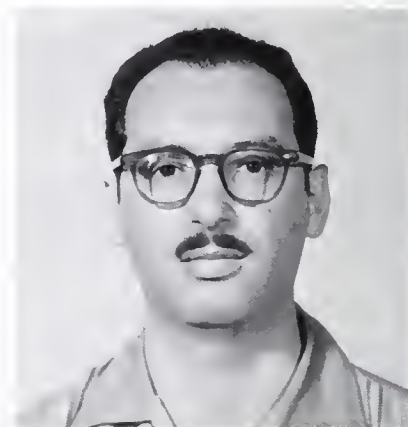
P. O. Box 546

Kailua, Hawaii 96734

GENERAL PRACTICE

Loma Linda University—1970

Internship—Riverside General
Hospital—1970-1971



Bernard M. Scherman, M.D.

Box 730

Kailua, Hawaii 96734

**EMERGENCY MEDICINE
AND PEDIATRICS**

University of Bologna, Bologna,
Italy—1964

Internship—Queens Hospital,
New York, New York—1965-1966

Residency—Queens Hospital,
New York, New York—1966-1967

Children's Hospital, Honolulu—
1969-1971

HAWAII MEDICAL JOURNAL



Fred C. Holschuh, M.D.

P. O. Box 730
Kailua, Hawaii 96734

EMERGENCY MEDICINE

Columbia University—1967
Internship—Queen's Medical Center
—1967-1968
Residency—Kauaikeolani Children's
Hospital—1970-1971



Richard B. Langer, M.D.

Molokai Clinic
Box 218

Kaunakakai, Molokai 96748

GENERAL PRACTICE

University of Minnesota—1964
Internship—Tripler Army Medical
Center—1964-1965
Residency—Queen's Medical Center
—1967-1968



Ben Leung, M.D.

1834 Nuuanu Avenue
Honolulu, Hawaii 96817

**INTERNAL MEDICINE &
CARDIOLOGY**

University of Missouri—1968
Internship—St. Francis Hospital,
Honolulu—1968-1969
Residency—St. Francis Hospital—
1969-1971
Queen's Medical Center—1971-1972

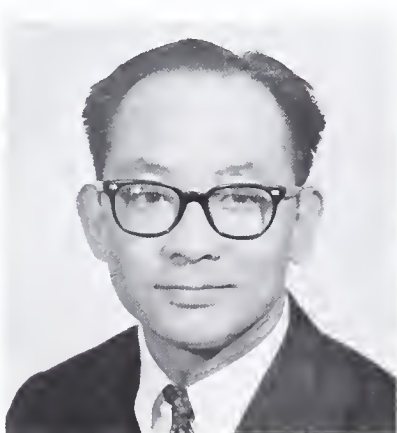


Raymond M. Taniguchi, M.D.

888 South King Street
Honolulu, Hawaii 96813

NEUROSURGERY

Tulane University—1960
Internship—McLeod Infirmary,
Florence, S.C.—1960-1961
Residency—North Carolina
Baptist and Duke University—
1961-1970



Charles K. Tashima, M.D.

2260 Liliha Street
Honolulu, Hawaii 96817

INTERNAL MEDICINE

Harvard Medical School—1956
Internship—Bellevue Hospital,
New York—1956-1957
Residency—Memorial Center,
New York—1957-1958
Memorial Center, New York—
1960-1963



John B. Thompson, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

OPHTHALMOLOGY

Indiana University School of
Medicine—1964
Internship—Memorial Hospital of
South Bend, Indiana—1964-1965
Residency—University of Illinois Eye
and Ear Infirmary—1967-1970

Life in These Parts

At a recent Workmen's Comp meeting, **LQ Pang** was introduced by attorney **Tom Rice** as **HQ Pang**, his brother . . . whereupon LQ felt it imperative to relate how an ingenious woman patient kept the brothers and their specialties straight. . . . LQ (an ENT man) was "Larynx Quinsy" and HQ (who does OB) was "Hymen Quinsy" (as related by **Jon Won**).

The Russians Are Coming . . . HMA exec secretary **Tom Thorson** was tearing his already sparse hair . . . "I'm up a wall . . . The Russians are driving me crazy." Tom had received an urgent call from AMA headquarters asking that he entertain two Russian physicians attending the International Emergency Medicine Symposium here. First, the Russians arrived at the Hawaiian Village without any reservations . . . so Tom solved that situation. He then made dinner reservations at Kuilima and got tickets for the Polynesian Cultural Center show. . . . "Then everybody got into a flap" because the Russians had no such instructions, and were afraid to leave the hotel. . . . So, hasty phone calls had to be made to the State Dept. which contacted the Russian Embassy which in turn cleared it through Moscow. When permission was finally obtained, the Russians ventured forth. . . .

Quotes from **Bob Midkiff**, American Trust Company president, during a recent weekend incorporation seminar at Kuilima:

- "The poorest training for handling money is a doctor's training" (referring to the years of low income during training, and then suddenly coming into substantial earnings on starting a practice).

- re, estate planning: "The difference between a fine old gentleman and a bum is your money. . . . So keep your money. . . . Don't give it away too early. . . ."

- "A patient had a splitting headache and finally went to Johns Hopkins where he had a tumor removed. When he woke up, the headache was gone, but there was a new pain between his legs. "What gives?" he asked the famous neurosurgeon. "Well," replied the surgeon candidly, "I got such an ovation from the audience that I performed a circumcision for an encore."

- Bishop Kennedy in his earlier years frequently preached at outlying churches. After concluding one of his better sermons, one of the church ladies came forth with a \$10.00 honorarium, which he politely returned. She was profoundly grateful and gushed, "Oh, thank you. Now we can put it into our fund." "What fund is that?" he inquired. "It's a fund to get better speakers."

Al Chun-Hoon and **Fred Warshauer** gave up a Wednesday afternoon golf game to testify at a Workmen's Comp hearing on the 1970 RVS schedule. Their testimony was third on the agenda and scheduled for 2 P.M., but as usual, the schedule got fouled up. At 2:30, Fred was heard to mumble, "I could be on the 2nd green by now." Two hours later and still waiting, Fred muttered, "I could have been on the 9th hole by now." (Methinks we owe a lot to the gallant few who would even sacrifice their golf afternoons for the benefit of others. . . . So many owe so much to so few. . . .)

During a Kuakini surgical conference, neurosurgeon **Max Urata** discussed acute head injuries and mentioned that older patients with atrophic, smaller brains have a lesser mortality from subdurals than those with normal brains. **Henry Oyama** was curious, "At what age do you find the brain atrophic and smaller. . . . You know, for our benefit." Max replied, "After 40." Henry, pushing 40, looked a little worried. . . .

Sports

Fishermen: A group including **Tom Frissell**, **Ted Tseu** and **Murray Berger** fished over the July 4th weekend off Niihau from the Kuu Huapala. Ted and Murray both landed 175-pound ahi, while Tom had to settle for a 150-pounder. The group also got eight 30- to 40-pound ono, and eight mahimahi, including a 40-pounder landed by Ted on 20-lb. test line and taking him all of 40 minutes. . . .

Golfers: Only recently did we learn that modest **Glenn Kokame** had made a hole-in-one in June on the Mid Pac 4th hole, using a 5 iron. Playing in his foursome were **Dick Ho**, **Henry Yim**, and **George Leary**.

Medical Arts Golf Tournament:

The annual Medical Arts Golf Tournament was held at Mid Pac on August 3, run by last year's co-winners, **Ed Emura** and **Don Maruyama**. Interest in this tournament is generated less by the prizes than by the jackpots and a money-losing scheme called the "Calcutta" (wherein one puts in cash and receives points). In Jackpot No. 1, the winners were **Dick Ho**, **Dick Lam et al**, while in Jackpot No. 2, **Ed Matsuoka** was the winner. In the Calcutta, the team of **Dick Ho** and **Masa Koike** came in 2nd while **Dick Lam** and **Art Salcedo** came in 3rd. In the Guest Flight, the winners of the tournament with net 69's were **Clarence Sakai** and **Dick Ho** and in 8th and 9th places with net 71's were **Dick Lam** and **Coolidge Wakai**. In the Medical Arts Flight, **Art Salcedo** with a net 71 won first prize and the honor of conducting the next year's tournament, while **Ed Izawa** won 2nd place. Others winners were **Nobu Nakasone**, **Paul Tamura**, **Y. Fukushima**, **Frank Fukunaga** and **Ike Nadamoto**. **Paul Tamura** MC'd the post-tournament banquet. . . . "Welcome to the 11th or 12th Annual Medical Arts Tournament. . . . We will start by introducing the landlord and his wife (viz **Diek Sakimoto** and **Edna**. . . . Tonight is a special occasion for them. It's their 25th wedding anniversary. . . . **Ed Emura** will do the honors . . ." and Ed did by smacking Edna right on her lips. . . .

First Annual Statewide Hawaii Pathologist Association Golf Tournament:

We have participated in many a tournament in the past, but nothing short of the St. Francis tournament ever came close to what Kapiolani Hospital pathologist **Tom Kobara** organized for the weekend of July 29-30 at Kuilima. Sixteen venturesome foursomes competed against the elements—gusty winds, rain squalls, unpredictable greens, and the traps, traps, everywhere. . . . The hardest were humbled and the most stoic had their nerves frayed. . . . Only those with real faith came through and we all became God-fearing men. . . . We remember the last hole, with all pushes going: **Dick Omura** faded one out toward the right fairway trap; a golf cart just happened to be there and the ball bounced back into the middle of the fairway. He then took his faithful 6 iron and placed his 2nd shot 3 inches from the pin for a gimme and a net 68. . . . We remember **Stan Saiki** shooting flawless golf for 15 holes and suddenly developing buzzards and triples but still coming in with a net 72. . . . These are the things we remember. . . . And we would like to forget the par 3 2nd hole where we blasted in and out of 3 traps before learning that the greens simply do not hold. . . . Have you seen grown men cry? . . .

But **Herman Mercado** was the wise one. . . . He abandoned his woods and stuck to his irons throughout the tournament and shot a net 65 the first day and a 69 on the 2nd for a total net of 134 and overall honors. Drug man **Les Bricker** was second with a net 139 while our traditional grand slam winner **Bill Dang** shot a 141 net for 3rd place. Other creditable scores were posted by **Garth Morimoto** in 6th, **Y. Fukushima** in 7th, **Neal Winn** in 8th, **Stan Saiki** in 9th and **Diek Omura** with his 78-68 in 10th. But the story does not end there for **Tom Kobara** had arranged the over \$1,000 worth of prizes so that everyone had a chance at them. **K. S. Tom** shot a net 73 for 4th place on Saturday while **Paul Tamura** with his 68 won Sunday's low net; **Chew Mung Lum** with net 70 was 2nd, **Ben Realiea** with 71 was 4th and **Hide Oshiro** with 72 was 5th. **Tom Thorson** with a 35½ won Saturday's front 9 low net and **H. Yokoyama** took the back 9 with a 33½. On Sunday, **Masaru Koike** was first with a net 34½, **Catalino Cachero** 2nd with 35 and **Calvin Kam** and **Tom Kobara** tied with net 36's. On the back 9, **Henry Yim** was 2nd with net 33, and **Art Saleedo** and **Ray Wong** tied with net 36's. Consolation prizes were awarded to **Bill Ito**, **Roy Iritani**, **Ed Kagihara**, **Bob Kim**, **James Young**, **Mannel Abundo**, **Fred Lam, Jr.**, **Ed Izawa**, **Vic Mori**, *et al.* **Francis Soon**, who of late suffers from a malady known as the "Ball Fixation Syndrome" was winner of the high net. (As **MC Herb Minn** put it, "he's the guy with the most guts and the most honest handicap. . . ." **Francis** shot nets 64-64 and 64-64, and that's some consistency. . . .)

Oncology Dialogue

A 73-year-old Japanese man with a nasopharyngeal CA irradiated 4 years ago was admitted with a pulmonary lesion. A scalene node biopsy revealed an undifferentiated adenoCA. The academic question was whether or not this was a second primary. ENT man **Hideo Oshiro** wanted to know. Pathologist **Grant Stemmerman** was no help: "Its the same undifferentiated CA." **Mel Kaneshiro** concurred, "All them guys look alike." Surgeon **Bob Oishi** tried to bring the discussion back into focus: "What is **Hideo** supposed to do?" **Quint Uy** was conciliatory: "Irradiate."

A 69-year-old woman with idiopathic thrombocytopenia, adenoCA of the breast and Paget's nipple had a rt radical mastectomy 2 years ago. In January, she had a lt simple mastectomy for recurrent tumor, and to complicate matters, required 5 units of platelets. Moderator **Noboru Oishi** asked radiologist **Ed Quinlan**: "Ed, would you treat her chest wall and her internal mammaries?" Ed was frank: "I'm hesitant on this lady. . . . She's a bitch on wheels." **Quint Uy**: "I would consider estrogens and see if there is any response within 6 weeks to see if the tumor is hormone-dependent. Estrogen is standard therapy. . . ." **Grant** disagreed, "Standard therapy is not necessarily standard reaction." **Noboru**: "What are you saying? . . . I would agree with **Quint**, and give estrogen." **Stemmy** growled: "Leave her alone. . . . Each person's response to steroid therapy is different." **Noboru** smiled acquiescently, "Well, okay. . . . The lines are drawn. . . ."

An 88-year-old woman with CA of the vagina had been treated previously with cobalt and intravaginal radiation. She was hospitalized with a 10-lb. wt. loss, rectal bleeding, and a pelvic mass completely obstructing her lt kidney. A bladder biopsy showed epidermoid CA. The question was whether to do surgery for her lt ureter or do chemotherapy. **Noboru** suggested a combination of bleomycin and vincristine. **Stemmy** was skeptical: "How alert is she? Your chemotherapy will be a failure otherwise. . . ." **Quint** asked, "How much time do you need? Bleomycin required 4 to 6 weeks." **Noboru**: "I had planned a 150-mg total dose. If her time is up, or nearer or nearest, and if no drugs, would you do a diversion? . . . If she was the president of the US, wouldn't you recommend she complete her obligations?"

Quint Uy carefully skirted the issue: "You may want to divert. . . ."

A 44-year-old woman with a diffuse type adenoCA of her stomach had a 90% resection with **Bilroth I**. **Stemmy**: "This was a Stage I. No chemotherapy recommended." Her surgeon **Bill Morioka** elucidated, "She had symptoms for 4 years. Her first UGI was benign, but 6 months later, a repeat GI series showed a slight nodularity." **Quint** took the cue, "Which shows X-rays are not infallible. Certainly if I had a gastric ulcer, I would have a gastroscopy." **Noboru**: "How long would you wait?" **Stemmy**: "The longer the symptoms, the better the prognosis." **Minoru Kimura** asked, "What is the feeling of this group with gastric ulcers? Would you do surgery right away?" Internist **Quint Uy**: "I think gastroscopy with biopsy and careful followup if benign." Surgeon **Bill Morioka** was dogmatic: "Do surgery right away. Some patients sit in hospitals for weeks and do not improve. . . . It is a waste of time and money." **Noboru**: Most of us would do a gastroscopy and if benign, sit on it. The next question is, why X-rays? Radiologist **Ed Quinlan** pleaded, "It would ruin our department. Do an UGI as an initial screening procedure. . . ."

A 66-year-old Japanese man with epidermoid CA of the hypopharynx was diagnosed and treated with extensive sequential radiation in 1967. He was admitted with a low PO₂ and a high SGOT. Radiologist **Carl Boyer** asked, "What were the indications for treating sequentially?" **Noboru**: "What would you have done?" **Carl**: "Treat sequentially." **Grant** reported, "Epidemiologically, this type of tumor occurs in heavy smokers." Tripler radiologist **Sidney Kadish** commented, "Patients with tumors at the base of the tongue are the worst citizens." **Noboru** turned to **Quint Uy**: "What do you plan to do now?" **Quint** despaired, "We keep repeating blood gases. . . . I guess Bleomycin is the only treatment left."

A 67-year-old woman had a lt radical mastectomy and postop irradiation and recently developed several skin nodules and possible metastatic lesions of her lt lung. Oncologist **Jack Keenan** was aghast: "Skin nodules in the irradiated area? I thought this never occurred." Radiologist **Carl Boyer** explained, "We get accused of many things, such as skin nodules in non-irradiated skin areas and pneumonitis in non-irradiated lung fields."

A 79-year-old man with prostatic CA and metastases had a TUR a year ago and had been on standard therapy. The question now was what to do for him next. **Noboru** asked, "He's not uncomfortable, is he?" **Tom Fujiwara**, "He feels no pain because he's obtunded." **Noboru**: "It all goes back to his age." "Gung ho" **Jack Keenan** protested, "But that's where you start!" **Noboru**: "Physiologically, prostatic CA is associated with old age. So how aggressive should we get?" **Carl Boyer** added, "Either hold back his sex life or his golf game." **Noboru**: "How about a ³²P protocol?" **Carl**: "Only if there is generalized bone pain." Our pathologist **Grant Stemmerman** frowned: "And not terminally. . . . Makes for complicated autopsies."

Aetna Medicare Meeting

Chairman **Gabe Ma**, noting that **LQ Pang** had no assigned charts for the evening, remarked, "LQ, you get a free meal tonight." Whereupon **Bill Dang** came to **LQ's** defense: "But he's asking questions." There was the usual surfeit of charts for the internists and general surgeons, while there was a paucity of review charts for the subspecialties, but then that's why physicians specialize anyway—to do less. . . .

Gordon Lin reviewed the case of a patient with frequent PVC's who was being monitored with Lead II once weekly in the office while the physician titrated the digitalis and pronestyl dose. **Bill Dang** quipped, "That patient's got a lot of rhythm. . . ."

A cardiologist protested when Aetna paid only half of his bill for the 35-day hospital care for an MI pa-

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Francisco in cooperation with the AMA Council on Voluntary Health Agencies and state medical associations of Alaska, Arizona, California, Idaho, Nevada, Oregon, Utah and Washington. No financial commitment is necessary from HMA.

Report of the AMA Delegate: Dr. Mills reviewed the activities of the AMA Convention held in San Francisco in June. A copy of his report is on file in the HMA office. He emphasized that the HMA must become involved in programs for Physician's Assistants and in setting down guidelines. He noted that the AMA has added student representatives to the House of Delegates and urged HMA to welcome the medical students, interns and residents to join the Association and to make any necessary bylaws changes in order that they may do so. The AMA Delegate was urged to strive for more than one delegate from Hawaii.

COMMUNICATIONS REQUIRING ACTION

AAMA: A letter was received asking for a contribution to the American Association of Medical Assistants.

ACTION:

It was voted to contribute \$25 to the American Association of Medical Assistants.

Letter from Wisconsin Health Care Review Organization asked for a copy of the criteria currently being used for HMA and information on criteria development. Dr. Iaconetti suggested that instead of sending the actual criteria that a letter be written giving information on the development of the criteria. It should also be stated that EMCRO is an experimental research study which develops criteria that is always changing and subject to review. The HMA does not see EMCRO involved in claims review but that its primary purpose is for research and education.

ACTION:

It was voted to answer the request for information according to the information suggested by Dr. Iaconetti, giving them background information and how the criteria was developed and also invite a physician member of their organization to visit our EMCRO offices.

It was further voted that this action would become the present policy of HMA.

Cancer Research Center: Dr. Chinn gave a progress report on the Cancer Research Center. A letter was sent to the Research Corporation insisting on the original composition of the Executive Committee to be four from the HMA, four from the University, two from the Cancer Society, one from the Department of Health and one from the Hospital Association.

Letter from EMCRO, re, Extended Care Facilities: Miss Charlotte Dennis has joined the EMCRO staff as the Coordinator for Extended Care Facility Project. A brief outline of the project was submitted to the Council as well as a letter listing recommendations for chairman and members of the ECF Educational/Audit Committee. Initially there had been concern whether EMCRO was able to take on another project but Drs. Anderson and Botticelli assured the EMCRO Board that this was feasible and the project was approved by the EMCRO Board on August 8. There were several inaccuracies regarding the project as outlined and it was again noted that EMCRO is not a peer review organization but is a research organization whose purpose is to develop guidelines which will help in the development of mechanisms for peer review. Dr. Mills stated that he was interested in the project because he felt it was time for organized medicine to become involved in the concept of ECF's. He feels it should be possible to determine when, for example, a stroke patient has reached an optimum level which will move him out of the acute general hospital into another facility.

ACTION:

A motion was made and seconded that the HMA approve of the EMCRO Project for a Quality of Care Study in Extended Care Facilities. A motion to table the discussion until Charlotte Dennis was contacted failed to pass.

ACTION:

It was voted to approve an EMCRO Project for a Quality of Care Study in Extended Care Facilities and that Miss Dennis be instructed as to how the Council feels regarding the study (regarding peer view, purpose of the study, etc.).

There was further discussion regarding the composition of the ECF Committee. It was generally agreed that the establishment of medical criteria requires the involvement of physicians rather than administrators. There were questions regarding the purpose of the committee and whether it duplicated existing EMCRO committees.

ACTION:

It was voted to leave the appointment of the chairman and committee members for the ECF Project up to the HMA officers.

Endorsement of Area Health Education Center Program: The School of Medicine at the University of Hawaii is one of 25 schools that have been invited to prepare a detailed contract proposal on health professions education program at Neighbor Island hospitals with the involvement of the existing health professionals and the community colleges. A meeting on this proposal was held the afternoon of the Council meeting and a letter of endorsement was submitted by Dr. John F. Morris, HMA representative, for Council approval of the project. The project was discussed at length. Dr. Smith spoke in favor of the project stating that this type of program was badly needed on the neighbor islands. A question was raised regarding the training of interns and residents on the island of Oahu, and whether a decision has been reached with the University regarding the responsibility for training. No decision has been reached. It was noted that this project would utilize local physicians for faculty and it was questioned whether the physicians on the Neighbor Islands would be able to provide the time necessary for the project. It was agreed that decentralization of training programs was a good idea but perhaps premature. Dr. Lee urged the Council to seriously consider the merits of the program rather than endorsing a project because there is Federal money available and because there is a three-day deadline to meet.

ACTION:

A motion was made to approve a letter of endorsement for the Area Health Education Center Program. The motion failed to pass.

REPORTS OF THE COMMISSIONS AND SPECIAL COMMITTEES

Commission on Education and Peer Review: Dr. Lee reported that the Publications Committee had recommended that the Roster be published annually but would wait until further information is received regarding an addendum. He reported that the HMA Peer Review Committee met once and has scheduled another meeting in early September. The committee feels its primary purpose is to establish guidelines so that peer review activities can be carried on uniformly throughout the state. He suggested that legislation be developed in order to tie-in Peer Review and licensing activities.

Dr. Lee suggested two other areas of legislation that are necessary: (1) to amend the law whereby physicians can dispense Class II drugs as originally stated in Senate Bill 310 and (2) encourage the State to assist in providing facilities for physicians in disadvantaged

continued page 412

Physician's Report of Services Rendered

HAWAII MEDICAL SERVICE ASSOCIATION



FORM 8
12/71

MEMBERSHIP NUMBER	COV.	PATIENT'S FIRST NAME	CHECK ONE	BIRTH DATE	SERVICE DATES
654023	7 04	Mary	3 ADULT MALE 4 ADULT FEMALE 7 JUVENILE 8 DOG	MO DAY YEAR 7 1 23	FROM MO DAY NO. TO MO DAY YEAR 7 4 7 10 72
SUBSCRIBER'S NAME	PHYSICIAN'S NAME		PROVIDER NO.		
John Smith	N. E. Doktor, M.D.		0012		
IF FEDERAL BLUE SHIELD - BLUE CROSS PLAN FILL IN		ADDRESS (IF NOT IN STATE OF HAWAII)		STATE ZIP CODE	
OTHER MEDICAL COVERAGE?		DATE		POSSIBLE WORKMEN'S COMPENSATION	
<input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF CARRIER		Fell 7/4/72		RANGE	
PATIENT'S COMPLAINT		DATE OF ONSET		DIAGNOSIS	
		7/1/72		Fracture: Femur	
SURGICAL PROCEDURE (USE STANDARD)		DATE		NAME OF HOSPITAL	
Suture of laceration		7/4			
CLAIMS FILED		DATE		M.D.	
JST		7/10/72			
STANDARD SERVICE VISITS		DATE			
		2000 58 22 50			
SURGERY		DATE			
		7/10/72			
OFFICE VISIT		CHECK IF NEW PATIENT			
		7/10/72			
HOSPITAL VISIT		DATE			
		7/10/72			
LABORATORY (Itemize)		UA			
		7/10/72			
X-RAYS (NO. OF VIEWS) (Itemize)					
IMMUNIZATIONS (Itemize)		90700			
DRUG		997			
INJECTION		999			
TAX		99980			
		37 00			
LESS PAID BY PATIENT		9982			
FOR DESCRIPTION OF UNUSUAL OR COMPREHENSIVE SERVICE USE REVERSE SIDE		NEW CHARGE			
REMARKS:					

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N. E. Doktor, m.d. 7/10/72

DOCTOR'S SIGNATURE

DATE



Hawaii Medical Service Association

communities where zoning regulations often prevent medical facilities.

Commission on Internal Affairs: Dr. Ballard recommended that the theme for the 1973 annual meeting be changed to "Acute Medical Emergencies" and that the original theme "Clinical Pharmacology and Therapeutics" be postponed to 1974. The meeting is scheduled for April 30-May 5, 1973, at the Ilikai Hotel.

ACTION:

It was voted to accept the recommendation of the change in theme for the annual meeting.

Bylaws: The final report of the Ad Hoc Committee on the AMA Study of HMA was transmitted to the Council by Dr. Mills. The Ad Hoc Committee recommends that their committee be disbanded. They further recommend that the constitutional convention be held on a Saturday and Sunday and offer to serve as resource people at the committee hearings.

Dr. Iaconetti reported that he has called a special officers meeting for August 18 to review the report and make definite recommendations. A special Council meeting will be called for September 1 to review the recommendations of the officers which will then be turned over to the Bylaws Committee and finally to the House of Delegates.

ACTION:

It was voted to accept the report of the ad hoc committee and that the Ad Hoc Committee on the AMA Study of HMA be disbanded with the best wishes and congratulations of the Council. The dates for the Constitutional Convention will be November 4 and 5, 1972.

Commission on Medical Services: A report on the current status of the legal suit against the Department of Labor regarding the Workmen's Compensation schedule was presented for the Council's information by Dr. Chun-Hoon. In essence, a brief has been prepared and will be submitted as an administrative appeal to the Circuit Court. The HMA is appealing the conversion factor as well as the definition of a specialist as established by the Director of Labor. The case will probably come to trial in late October.

Commission on Public Health: The Council accepted the recommendations of the Commissioner, Dr. Sia, as follows:

ACTION:

It was voted to approve (1) the "Statement on School Health Functions, October, 1971" which states the primary health care of the patient should be the responsibility of the child's parents in conjunction with their private physician and that the school acts as the screening agent in various programs but does not initiate primary medical care; (2) that immunization be directed through a program of primary immunization in infants and preschool children before they are 18 months of age; and (3) that the HMA does not favor the establishment of immunization clinical services for children in special geographic areas.

Dr. Winn presented the recommendations for endorsement of "Warm Line" and a booklet on "Guide to the Perplexed." "Warm Line" is a telephone call-in program funded by Roche Laboratories whereby physicians can call to get taped information on symptoms, management, and referral programs for substance abuse problems.

The committee has reviewed the medical content of the tapes and recommends Council approval.

ACTION:

It was voted to endorse the concept of the "Warm Line" project.

The Substance Abuse Committee also recommends the endorsement of a booklet entitled "Guide for the Perplexed" which will be sold to physicians as well as other professional persons. The booklet deals with medical treatment, legal aspects, referrals, signs and symptoms, etc. of substance abuse. Supplements to this booklet will deal with alcohol which removes one of the original objections to the booklet.

ACTION:

It was voted to accept the recommendation of the Substance Abuse Committee and endorse the booklet "Guide to the Perplexed." There were three opposing votes.

Dr. Sia reported that he had written a letter recently speaking strongly against "mass" physical examinations of children prior to attending camps. He encouraged the HMA to respond accordingly to similar requests.

Drug Alert: It was noted that physicians should again be reminded not to leave their prescription pads out as they have been stolen.

Commission on Interprofessional and Public Affairs: It was reported that Careers Day has been scheduled for October 18, 1972, at the HIC. A request for \$300 from the Medicine and Religion Committee for printing of the proposed brochure "When Illness Comes . . ." was reviewed.

ACTION:

It was voted to approve the request for \$300 for printing the brochure "When Illness Comes . . ." and that the \$300 budget for 1973 be deleted.

Commission on Health Service and Care: Dr. Gilbert reported that the Community Health Committee proposes a policy statement for the HMA on the Kaiser-OEO project in order to avoid any misunderstandings. Dr. Reppun also presented a draft of a letter to be sent to the AMA on the same subject because he feels that the national association should know what has happened here. It was pointed out that the President devoted his page in the July-August 1972 issue HAWAII MEDICAL JOURNAL to this subject.

ACTION:

It was voted to reaffirm the President's stand on the Kaiser-OEO project as expressed in the July-August issue of the HAWAII MEDICAL JOURNAL.

ACTION:

It was voted to send the letter drafted by Dr. Reppun to the American Medical Association Council on Medical Service. There was one opposing vote.

Emergency Medical Services: Dr. Chinn outlined some of the problems which have been encountered in negotiations regarding the Emergency Medical Services grant. Dr. Hasegawa concurred there are some problems.

Cancer Commission: Dr. Batten reported that a contract between the Hawaii Tumor Registry and the Cancer Demographic Study is presently being worked out which will allow the Study to use certain information from the registry.

ACTION:

It was voted to allow the officers to make the final decision on the Tumor Registry contract with the Research Corporation of Hawaii and enter into a contract if the final terms are satisfactory.

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ASK ABOUT ADCO-10

UNFINISHED BUSINESS

Association of Professions Bylaws had been circulated to the Council. Drs. Schnack and DeJesus reviewed the background of the Association of Professions and noted that as soon as three organizations have indicated their willingness to join, the Steering Committee for AOP will apply for a charter. The HMA will hold membership as an Association and members of the HMA can apply for individual membership as well.

ACTION:

It was voted to approve the Bylaws of the Association of Professions.

Publicity Code: A copy of the proposed Publicity Code for Physicians as submitted by Honolulu County was circulated to all component societies for their comments. Verbal approval was received from Hawaii County and Maui County suggested two amendments.

ACTION:

The Council voted to approve the Publicity Code for Physicians as reprinted below:

Hawaii Medical Association PUBLICITY CODE FOR PHYSICIANS

The Hawaii Medical Association recognizes that good public relations is vital and possible only through the active cooperation of physicians with the news media. To this end, physicians should be willing to appear on television, radio and in the press whenever called upon, in accordance with the following general principles:

1. When contacted by the news media for comment or information, a physician should reply frankly and openly, provided the subject is within his jurisdiction, cognizance and specialty; otherwise he should refer the media to the proper authority on the subject.
2. News media appearances are allowed in connection with scientific meetings, medical happenings, and legitimate medical procedures of public interest.
3. News media appearances for the obvious purpose of self-aggrandizement or self-publicity are to be condemned.
4. The physician may be identified by name, specialty, organizational membership, educational background and institutional affiliation; but should not be identified with any unique or special procedure, treatment, skill, or results or other self-laudatory information.
5. In any news media appearances, the physician should stress joint, rather than personal effort; and endorse only those drugs, treatments or procedures which are generally acceptable to the profession. He should not claim special skills, procedures or treatments; neither should he claim more skilled or conscientious care or better results than his colleagues.
6. The physician may release to the news media the results of his research or experiments provided it has been reported to and accepted by an appropriate national or regional medical organization, or accepted for publication by a national or regional medical journal or repute.
7. It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

8. News media appearances in connection with non-medical newsworthy events is permissible provided the physician's identification is kept minimal.
9. Whenever questions of propriety arise, the physician should consult with or clear through the appropriate committee of the medical society.
10. Whenever news releases of import to the medical society are planned, the physician should report such information to the executive director or president of the society.

University of Hawaii/DSS Study: A copy of a letter prepared for certain HMA physicians outlining the consumer satisfaction survey being undertaken by Dr. Worth was circulated to the Council. The Council has previously approved this project.

NEW BUSINESS

Employment Service: Dr. Iaconetti noted that he has asked that the possibility of operating a medical placement service be explored. This will be discussed further after obtaining more information.

Election of HAMPAC Board: The following doctors were appointed by the President with the concurrence of the Council: Drs. Ed Ballerini, James Matayoshi, Pete Okumoto, Sakae Uehara, Mark Sowers, William Iaconetti, Harold Lawson, Rodman Miller, L. Q. Pang, Leslie Vasconcellos, Bernard Fong, Howard Liljestrand, B. Allen Richardson, George Goto, Peter Kim, Katok Chuang, and Mrs. George Mills and Mrs. Jerome Tucker.

ADJOURNMENT

The meeting adjourned at 11:15 p.m.

Respectfully submitted,

R. VARIAN SLOAN, M.D.

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the real
thing



COCA-COLA BOTTLING COMPANY
OF HONOLULU, INC.

COUNCIL MEETING

September 1, 1972 — 5:00 P.M.
Mabel Smyth Conference Room

PRESENT

Dr. William E. Iaconetti, presiding; Drs. Herbert Y. H. Chinn, Thomas P. Frissell, R. Varian Sloan, Grover H. Batten, George Goto, J. I. F. Reppun, Peter Kim, Ed B. Helms, Sakae Uehara, Winfred Y. Lee, Denis Fu, DeWitt H. Smith, Calvin C. J. Sia, Douglas Bell II, Masato M. Hasegawa, Rowlin Lichter, and Elisabeth K. Anderson plus Mrs. Pat Schnack of the Woman's Auxiliary.

CALL TO ORDER

The meeting was called to order by President Iaconetti.

MINUTES

The minutes of the August 11, 1972, meeting were approved as circulated.

REVIEW OF AMA STUDY OF HMA REPORT

The Council devoted the entire meeting to review of the report of the Ad Hoc Committee on the AMA Study of HMA and other bylaws recommendations. Listed below are recommendations which will be presented to the Bylaws Committee and House of Delegates in November. The report of the AMA Committee should be used in conjunction with the actions listed below in order to provide the reader with all recommendations on the subject matter.

OFFICERS RECOMMENDATIONS

(Unless noted otherwise, Council concurs with recommendations)

AMA REPORT—PART I

*A. That the Hawaii Medical Association and the various county medical societies may enter into administrative agreements or contracts for administrative sharing on a mutual basis. Should be permissive and statement should keep in mind the financial realities.

B. Allow Physician's Benevolent Fund moneys to be used for new physical plant.

ACTION:

That the House of Delegates be asked to include use of PBF moneys in rules and regulations. Motion failed to pass. *Note:* Council agreed that all subjects relating to Association activities, organization, etc. in addition to Bylaws will be considered at the Constitutional Convention.

C. (I) *(a) Unlimited tenure for Councillors. Two year terms instead of three.

ACTION:

That the term of a Councillor shall be for two years not to exceed six consecutive years. Motion failed.

ACTION:

That the present Bylaws be followed; two three-year terms for Councillors for a total of six consecutive years. Motion failed. Officer's recommendation stands.

(b) Delete: retain present size of Council.

ACTION:

That the Presidents of the four county medical societies be voting members of the Council. Motion failed.

*(c) Delete: retain present size of Council but add Alternate Councillors who shall be elected annually to serve when regular councillor is absent.

†(d) Keep responsibilities for transportation under HMA.

(e) Retain present language in Bylaws regarding frequency of meetings.

(f) No reference to meetings on Neighbor Islands.

*(g) Councillors and alternates should be nominated by their respective county medical society and elected at the House of Delegates.

*(h) President should continue as Chairman of the Council. Recommend that Speaker of the House of Delegates and Alternate Speaker be included in Bylaws.

C. (2) (a) Have already increased the use of ad hoc committees.

*(b) The President shall appoint committee chairmen and members; the president of each county society may recommend their representatives to a committee or commission.

*(c) When a member of an appointed or elected committee through resignation or death does not complete his term as a member of the committee or when he fails to attend less than 50% of the scheduled meetings during any year of tenure, the President may appoint a member to complete his term.

(d) Delete recommendation.

*(e) Chairmen of the commissions shall be appointed annually.

†(f) (g) (h) Agree that liaison with specialty societies, medical school, press and community should be working policies of HMA.

*D. *Duties of the Executive Director:* The Council is empowered to employ an Executive Director. The Executive Director shall be charged with the responsibility of carrying out the policies and programs of the Association under the general direction of the President. The staff shall be his responsibility to support the activities of the Association. He shall employ staff as necessary and shall establish salary schedules, and determine compensation rates commensurate with responsibilities assigned. The compensation of the Executive Director shall be set by the Council. The duties of the staff shall be delineated by the Executive Director. The Executive Director may employ one or more Assistant Executives with approval of the Council. The Assistant Executives shall carry out responsibilities as assigned by the Executive Director.

E. Included above.

F. Included above.

†G. Equipment: working policies.

*H. Consider removing budget responsibilities from the House of Delegates to Council. (Officers have mixed opinions regarding this recommendation.)

ACTION:

That the ultimate fiscal responsibility remain in the House of Delegates but that the Council be given broad powers within certain confines. Motion passed.

*I. All publications shall be the responsibility of Publications Committee. (See also, Publications Committee function.)

†J. *(1) Recommend addition to Bylaws, Chapter VI, Section 3, which will allow discussion of non-scientific subjects at the annual meeting.

ACTION:

Amend the Bylaws in order that the Scientific Meeting "may include subjects other than those of a scientific nature."

†J. (2) Agree that orientation program for new members is a good idea.

ACTION:

By deleting everything after the word "compulsory" in the committee report, this program

* Bylaws change needed.
† Working policy.

then becomes compulsory for all new members without specifying exactly when this program will be held.

(3) Agree that support be given to special programs.

PART II

A. Accept report and recommendations regarding BME.

B. Accept report and recommendations regarding Foundation for Medical Care.

C. Accept report and recommendations regarding Library.

*Delete last sentence of Chapter V, Section 3 (c).

D. Agree that these be working policies for Legislative Committee.

E. (1) Disagree with recommendation regarding county presidents as voting members of Council (see above).

(2) See Part I C 1 (g) above.

(3) See Part I C (2) (b).

(4) Agree.

(5) Are trying to do this.

(6) See Part I C (1) (e) (f).

†(7) Regular visits of the Executive staff should be scheduled with neighbor island county societies—could be combined with the visit of the President.

(8) The President may be eligible for reelection for two consecutive terms; this will change position of President-elect to Vice-President.

ACTION:

Delete the phrase "for two consecutive terms." Motion failed.

ACTION:

That the Council does not agree with the recommendation of the officers and that the present language in the Bylaws be maintained. Motion carried.

*F. HMA Charter (article IV) needs to be changed to read the same as Bylaws, Chapter II, Section 1, regarding membership for interns, residents, etc.

ACTION:

In addition to changes recommended by the officers, Council recommends that medical students be accepted as members of the HMA as Special members. Motion carried.

†G. Working policies. Officers suggest that an ad hoc committee be appointed in order to determine problem areas where policy statements are required for submission to the Council.

OTHER BYLAWS RECOMMENDATIONS

* (1) Add verbiage which will allow seating of substitute delegates (other than delegate or alternate delegate) at the request of the county president when there is no duly elected delegate present provided the substitute is a duly qualified member of the Association.

* (2) Past presidents shall be voting members of the House of Delegates but shall not be included in the makeup of the quorum.

* (3) Increase the size of House of Delegates. Add seat for representative of SAMA or House Staff.

ACTION:

Recommended that officer's recommendation not be approved. Motion failed.

* (4) Remove budgetary considerations from House of Delegates and give authority.

ACTION:

Agree with action taken above in Part I, "H."

* (5) Allow refund of dues to estate of deceased member with Council approval; or delete any reference in Bylaws (Chapter IX, Section 2).

* (6) Description of functions for all committees and commissions.

Section on Committees and Commissions should delineate the channel of communications to be followed: Actions of Committees—Commission—Council—Commission—Committees.

Bureau of Research and Planning: The Bureau of Research and Planning shall consist of not less than ten members serving for three-year terms, four being elected each year by the Council from nominees presented by the President of the Association. The chairman shall be appointed by the President with the approval of the Council. It shall be directly responsible to the Council and the President of HMA. It shall consider such matters as are referred to it by the President and the Council. It may initiate study projects on its own. After due deliberations and the holding of hearings on a matter, it shall make recommendations to the Council for action and implementation by other HMA committees. The Bureau should function as a forward-looking committee with broad viewpoint, to help guide the HMA in its future course and objectives."

Communicable Disease Committee: To keep the HMA members informed on the current status of immunization and communicable diseases namely the contagious diseases such as Tuberculosis and Venereal Disease. To promote and coordinate the programs involving the above.

Publications Committee: (As adopted by Council) The Publications Committee shall consist of the officers of the Association and such other members as the President may deem necessary, with the Editor of the HAWAII MEDICAL JOURNAL ex officio. It may advise the Editor in setting editorial policies and in reviewing manuscripts, and determine fiscal policies and advertising standards. It shall submit to the House of Delegates annually its nominee for Editor of the JOURNAL. The Publications Committee shall be responsible for all publications of the Association.

Public Safety Committee: The Public Safety Committee will be an advisory body to the Commission on Public Health on matters relating to but not limited to automotive safety, water safety, and radiation. It shall study legislation pertaining to medical aspects of public safety and make recommendations. In addition, it may work with appropriate doctors, hospitals, and government agencies in surveillance of radiation to insure safety to patients and personnel; and it may compile statistical data on water accidents and suggest programs for community benefit.

Fee Survey Committee: The Fee Survey Committee shall make surveys of fees, assign nomenclature for procedures, specify the relativity between procedures throughout the State, from time to time revise and publish the Hawaii Relative Value Studies, and shall be responsible for any negotiations relating to fees.

Substance Abuse: To serve as a body with more than the usual knowledge about dangerous substances, their use and abuse, and professional responsibility regarding them, advising the Council and HMA membership in this area; represent the HMA on government committees on substance abuse; to encourage increased voluntary activity by members of the HMA in community substance abuse programs dealing with prevention and education, or rehabilitation.

Public Affairs Committee: To coordinate, develop and lend technical assistance to approved public relations activities originated by this committee and suggested by other committees of HMA, to manage and coordinate, with the approval of the Executive Board of HMA, the awards and nominations for awards in the community and HMA, to coordinate and assist and otherwise promote awareness of the medical needs of the Pacific Basin.

Chronic Illness and Aging: (Committee recommends name be changed to Chronic Illness Committee.) The

Chronic Illness Committee shall endeavor to stimulate the community to elevate the quality of care of patients with chronic diseases. This may include promotion of educational programs for both the medical profession and the lay public, as well as consultation to government and private agencies in regards to prevention, detection, and rehabilitation in the field of chronic disease.

ACTION:

Council recommends name of committee be changed to **Chronic Diseases and Geriatrics Committee** and that phrase be added to end of first sentence as follows: ". . . with chronic diseases or problems due to aging." Motion carried.

*(7) Add recommendation that Bylaws of the Association shall be reviewed no less frequently than every five years.

*(8) Allow Executive Board to exist with power of function. (All references to "officers of the Association" should be changed to "Executive Board.")

*(9) Chapter IX, Section 4. Assessment. The Council may levy assessments not to exceed \$25 per member per calendar year. Any assessment greater than that amount shall be levied by the House of Delegates.

*(10) Chapter X, Section 1(a). Requires change of fiscal year to be from January 1 to December 31.

*(11) The Executive Board shall be authorized to approve nonbudgetary items up to a total of \$1,000 in any calendar year.

*(12) If budgetary considerations remain in the House of Delegates, consideration should be given to *changing* the policy of allowing the Council the authority to approve expenditures not budgeted by the House to amounts higher than \$3,000 for any one item or \$5,000 in any fiscal year.

*(13) Chapter III, Section 5. Duties of Officers. (a) Add "The President may have an Assistant who shall be a member of the HMA." Also, change (7) under same section to read "that the President and his designees shall attend the annual and clinical meetings of the House of Delegates of the American Medical Association."

ACTION:

The Council did not concur with officers and recommend that (7) be changed to read: "That the President, President-elect, AMA Delegate, and Alternate AMA Delegate shall attend the annual and clinical sessions of the American Medical Association."

*(14) Add section regarding duties of AMA Delegate and Alternate Delegate.

COMMUNICATIONS REQUIRING ACTION

A. Letter from Hawaii Chapter of SAMA requesting \$200 donation was approved.

B. Drs. George F. Schnack and Cesar B. DeJesus were appointed as HMA representatives to the Hawaii Association of Professions.

ADJOURNMENT

The meeting adjourned at 11:00 P.M.

Respectfully submitted,
R. VARIAN SLOAN, M.D.
Secretary

Slants and Angles continued from 401

ways inconvenient and uncomfortable and usually eccentric. I question the whole concept of positive health and the validity of the prescriptions claimed to insure it."

Some interesting food for thought.

W. P. JONES, M.D.

Book Reviews continued from 403

Intelligence—Genetic and Environmental Influences

Edited by Robert Cancro, M.D., 312 pp., \$12.50, Grune & Stratton, Inc., 1971.

AS THE TITLE indicates, this book attempts to assess the contribution of genetic as well as environmental influences to that feature of personality we call intelligence.

The book is divided into three major sections: theory and measurement, genetic contributions, and environmental contributions. The book contains a series of statements of varying points of view regarding intelligence, sometimes quite in conflict with one another. The papers are a result of a conference on intelligence held at the University of Illinois, and it would have been useful if the editor had been able to put more life into the book by publishing some of the discussion which undoubtedly ensued after each paper. The book is not intended as a basic primer in intelligence, but is for the specialist in the field who is interested in what some of the current workers in the field think in this old nature-versus-nurture controversy.



KWONG YEN LUM, M.D.

**Progress in Neurology and Psychiatry
Volume XXVI**

Edited by E. A. Spiegel, M.D., 597 pp., \$29.75, Grune & Stratton, Inc., 1971.

THIS VOLUME is the yearly compendium of new developments in these fields during the past year. As such, it makes a handy yearly reference, and gives a good overview of the subjects covered.

KWONG YEN LUM, M.D.



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enumeration of a number of folk remedies. For example, it is described how sore eyes may be treated by scratching them with the remains of a cyst cut from a caribou which had been attacked by a fly. Further, there is a section aptly titled "Northern Highlights" consisting of abstracts of reports on medicine in the north, eg, fish tapeworm in western Alaska, botulism among Cape Dorset Eskimos, and plasma lipid patterns of Greenlandic Eskimos. The entire journal is pleasantly rendered, the printing of excellent quality, and I sense a tone of conservatism and reserve throughout the entire book.

In contrast, let us look at the March/April 1972 issue of HAWAII MEDICAL JOURNAL, a beautifully composed, well-organized book with a reproduction on the cover of a W. Hogarth engraving entitled "Don Quixote seizes the barber's bason for Membrines Helmet." Scientific articles relate to breast cancer, pulmonary embolism, air pollution, and then a local interest paper on starfish wounds. Those starfish are something else—irritating, not dangerous, but potentially a significant health threat—in Hawaii. The study on air pollution addresses itself to the problems of auto-

mobile exhaust gases at a large shopping center in Honolulu. This is a well documented study of a problem that can be just as great in Des Moines, Cedar Rapids, Sioux City, or Davenport.

Most state medical journals have a section devoted to news notes about their members, and Hawaii is no exception. The news editor, Henry J. Yokoyama, M.D., writes well in a serious as well as a jocular vein. He is abreast of the happenings of the Society and inserts notes on medical subjects as well as commentaries on the lighter side. In the March/April issue note was made of the appearance of Iowa's Donovan Ward, M.D., at the County Medical Society meeting, and his having been introduced as "a really great guy." A few jokes are interspersed—some of a type familiar to a popular magazine noted for its centerspread study in anatomy. Most of the news notes are serious and pertinent—good news coverage I am sure. The HAWAII JOURNAL is a beautiful publication, an inside view of the medical profession in a semi-tropical zone—more free and easy, yet just as serious and of as high quality as the State of Alaska.

I salute the staff members of these two excellent journals published by and for our medical colleagues in Alaska and Hawaii. Well done, and best wishes for the future.—M.E.A.



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tient. "You pay the cardiologist GP fees. . . . Medicare is encouraging Volkswagen medicine rather than Cadillac medicine. . . ." **Gabe Ma** commented, "He drives a Porsche" (which is the Cadillac of Volkswagens.) Eyeman **Jerry Faulkner** was aroused: "It's ridiculous not to pay the full doctor's bill for a MI patient." Cardiologist **Bernard Fong** explained, "I agree with you, but unfortunately the internists' fees are regulated by prevailing fees." **John Lowrey** commented, aside, "His argument is with the Federal Government, not with this committee." Bernard went on venting his feelings about the traditionally low fees for internists, contrasted to surgeons' fees. "We don't get paid for the anxiety involved in treating patients and for using our brains. . . . Why, I can do a spinal tap or pass a arterial catheter blindfolded. . . ." Surgeon **John Lowrey** whispered, "Sure, that's only surgery . . . that's easy." The battle of the internists and surgeons continued. . . . (Osler said: "It must be confessed that the practice of medicine among our fellow creatures is often a testy and choleric business").

Visiting Physicians

Marvin Cornblath, from Maryland Med School, who resembles a heavy, athletic version of Jack Benny, was the visiting pediatrics professor at KCH for July and August. He captivated his audience with a continuous, booming, uninterrupted dissertation which was awe-provoking—even his jokes did not get a pause for effect. . . . In discussing the care of the newborn, he showed slides of percentage curves of neonate survival. Then in apology, he said, "I remember Dr. **Schick Bela**, (of Schick test fame), then close to 90, who got up and said, 'Ladies and gentlemen, per cent means per hundred.' I'm guilty of doing the same thing." He recalled the early days of pediatrics when the pediatricians were not allowed in the nurseries. It was a "Don't do something . . . just stand there" era.

- re, the pHisoHex controversy: I glibly recommended discontinuing pHisoHex. . . . And all hell broke loose. . . . We hadn't been using pHisoHex for infant bathing anyway. . . . The hospital administrators were most happy because pHisoHex was more expensive than Betadine."

- re, walking donors: Our poor residents get typed and crossmatched with the nurses. We take for granted that their VDRL's are negative.

- re: antibiotic therapy in respiratory distress syndromes: We use penicillin and Kanamycin. It's never been proved to be efficacious, but we use it anyway. . . . Those coming to post usually have infection."

- re, infants of diabetic mothers: "Today, as **Dr. Waxman** puts it, I'm finally talking about something I know something about." He pointed out that 40 to 60% of infants of insulin-dependent diabetic mothers, and 80% of gestational diabetic mothers, have an uneventful course. About 30-45% of infants of insulin-dependent mothers have respiratory distress syndrome: 50% have hypoglycemia, 20% have hypocalcemia, 25-35% have hyperbilirubinemia, 10-15% have heart failure, 10-15% have polycythemia, and 6-13% have congenital anomalies. He recommends that the infants be placed in an intensive care nursery, should be looked on as very fragile infants and should be monitored for glucose, EKG, and electrolytes.

George Jordon of Baylor was the visiting professor of surgery for August and September. George, a medium statured, pleasant-faced, silver-domed, receding-forehead type with a mild Texas twang, gave well-organized, straightforward lectures chock-full of information. He covered postgastrectomy syndromes to occlusive diseases to plain ole appendicitis.

- To illustrate the difficulty of diagnosing appendicitis, he related how a physician's daughter, 6 months pregnant, developed a RLQ pain with normal WBC and temp. The gyn man attributed this to the stretching

of the broad ligament. . . . "It really helped my hair get grey. . . . We got there, as they always say, 'just before it ruptured.'"

- re, postgastrectomy dumping: "Most patients who have spontaneous remissions have found relief measures. . . . Most cases are relieved with medical management, but a few with very severe symptoms can be helped with a reverse segment. . . . Patients with gastric ulcers do not dump half as much as duodenal ulcers. Duodenal ulcer is an entirely different disease."

- re, total pancreatectomy: "As you can see, surgeons are very ingenious people. . . . There are at least 30 ways to sew back after removing the pancreas."

- re, prophylactic appendectomy: My answer to prophylactic appendectomy is yes. . . . There is no apparent increase in colon carcinoma after prophylactic appendectomy.

- re, diagnosis of appendicitis: The absolute dictum at Ben Taub Hospital is that the surgical resident sees every case of abdominal pain. (The accuracy of diagnosis at Ben Taub is 95%, compared to 78.7% at the VA Hospital.)

- re, perforated appendicitis: There is an increased incidence of perforated appendicitis in Houston and Cincinnati. . . . The problem of perforated appendicitis is a patient-related problem, rather than related to the outside physician's or the surgical resident's, observing too long.

- re, aortic grafts: We do a bypass only with sympathectomy. There is no need for excision. . . . Leriche was wrong.

- re, femoral grafts: In femoral-popliteal occlusion, amputation is associated with a greater mortality than with a femoral arterial bypass. Even with a 3-year patency rate, it is worthwhile, and the patient can be treated again if necessary. I consider it a minor operation, and patients are grateful.

- re, anterior and posterior tibial grafts: The treatment is a reverse saphenous vein graft in the common femoral artery.

KCH Quarterly Staff Meeting

Chief of Staff **Herb Nakata** has added a certain solemnity to these meetings by simply adding an opening prayer. We had always thought **OD Pinkerton** gave the best prayers, but we discovered that **Ed Kagihara** has the same talent. As Ed intoned, "Our Heavenly Father, we thank you for allowing us the opportunity to meet today at this quarterly staff meeting. . . . We thank you for your presence and watch in helping us care for the sick patients at this hospital and for your guidance to our various committee chairmen and their members. . . . Please continue to watch over all of us present here today and especially those who were unable to be here because of previous commitments, and who are ill. . . . Guide us O Lord in our discussions and decisions regarding this hospital so that we can provide the best medical and surgical care to the pediatric patients of our community. . . . This we ask in His name. . . . Amen" . . . we could feel spines tingle.

Sharon Bintliff reported on the Birth Defects Center. She warned, "You may be charged \$120.00 for chromosome studies, which have been free for the past 3 years. . . . The Feds are watching us. . . ."

Philip Alistair, acting chief of the Pediatric Pulmonary Center following **Alan Osher's** departure for UCLA, reported that RMP funds may be available for PPP (Pediatric Pulmonary Program) but not to the PPC (the center).

Philip Watt, chairman of Medical Records got up and pleaded, "I appeared before before you 3 months ago and not much results. . . . Please! . . ."

Administrator **Paul Cook** reported that KCH has operated in the black for the first time. (This despite the general census, which has been lower than last year, with an average occupancy of 59%.) He also reported progress on the proposed relocation to Kapiolani Hospital (of interest was that 508 questionnaires were sent with 201 responses, 170 voting for, and 31 opposing).

Professional Moves

Homo Sapiens Medicus, a most unique species, hibernates all year and stirs in July and August, which coincides with completion of residencies, give or take one month to recover from the rigors of training. . . .

Back in July, pediatrician **Ruth Matsura** left the Hilo Medical Group and launched out on her own at 1034 Kilauea Avenue, Hilo; surgeon **Wallace Loni** announced the opening of his Hawaii Kai Medical Clinic; **Robert Bell** and **David Rodwell** associated in the practice of family medicine at 305 Royal Hawaiian Avenue. We welcome back internist **Elmer Johnson**, who re-joined the Honolulu Medical Group, specializing in oncology. Internist **Steven Berman** has joined the Honolulu Medical Group and internist **Howard Keller** has joined the Windward Medical Center.

On Kauai, the Kauai Medical Group acquired four new members: **Maurice Girandier**, radiologist, who interned at St. Francis and trained a year at Queen's; **Jeffery Goodman**, who will man their Kilauea Branch Office; **Elbert Leigh**, diplomate of the American Board of Family Practice from Jackson, Wyoming; and **Rienzi Remitio**, anesthesiologist. In Kapaa, **William Downs** associated with **Patrick Cockett**. On the mental health front in Kauai, psychiatrist **Emily Khaw** was added to the Lihue Health Center and **Fred Weaver III**, chief of the Adolescent Unit at Hawaii State Hospital was appointed Chief of the Kauai Community Mental Health Center.

In August, radiologist **David Sakuda** associated with **Philip Lee** to help man the three offices at 880 Kam Hwy., the Medical Arts Bldg., and the A. Y. Wong Bldg. Two more ophthalmologists are back in town. . . . **Dennis Issei Machara** opened his office at the Manchester Bldg., 2080 So. King and **Donald Sroat** joined **William John Holmes** at 280 Alexander Young Bldg., and 105 Kailua Professional Center. OB woman **Ethel Omori Oda** is back and opened her office at 4210-7 Waialae Ave. On Maui, pediatrician **William Kepler** joined **Kenneth Haling** in Kahului.

Elected, Appointed and Honored

In July, Terence A. Rogers, interim dean of the UH Medical School for the past year, was officially appointed dean. "The selection committee was impressed by Rogers' deft, sensitive, and sensible performance as interim dean and the enthusiastic, widespread support for his candidacy. He handled a variety of difficult problems such as the negotiations with hospitals to be associated with the school, the legislative proposals which led to the approval of the four-year program, and a number of internal student and faculty concerns. He did these tasks with unusual competence and tact." Having seen Terry in action, we can attest to the above. . . .

Straub dermatologist **Bob Kim** was one of four chosen by the Pacific Army to go to South Korea as part of its Friendship Mission program; Straub internist **Namiko Kominami** has been appointed to the 12-member Hypertension Information and Education Advisory Committee of the National Institute of Health, which will pool scattered data on hypertension; and Hawaii's own **Richard You**, an official physician for the 1952 and 1956 US Olympic teams, and still quite active in Olympic affairs, presented a paper, "The Olympic Champion, 1972" at the Munich Olympic Medical and Scientific Congress on August 24; OB man **Charles Guy** is the new medical director of Hawaii Planned Parenthood, succeeding **Noni Koch** who will remain on a part-time basis.

Personal Glimpses

Maui's **Helen Percy**, who achieved a certain notoriety in becoming the first woman boxing physician, had a little difficulty climbing into the ring with her long muumuu to examine a boxer's bloodied eye. Someone heckled, "Next time wear your slacks." We suggest a miniskirt, but then Women's Lib is here to stay. . . .

Psychiatrist **Bob Bickel** at Hawaii State Hospital sent two separate cables to President Nixon (with nary a

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reply) asking for extension of the Coast Guard search for two State Hospital employees who disappeared while fishing on August 16. Bob is convinced that Arthur Allen, who worked for him, was an experienced enough sailor to stay alive out there for two weeks. . . .

Mild-mannered **Ira Hirschy**, in "an atypically blunt statement," blamed recent immigration to Hawaii for our rise in tuberculosis and leprosy. Ira pointed out that 70% of new TB cases last year were among immigrants, and half of them here less than a year, and that 85% of new leprosy cases over the past 2½ years were foreign or Samoan born, 72% of them from the Philippines.

When *Advertiser* columnist Lou Boyd, who lives on the mainland, warned that daily baths could be bad, **Harry Arnold, Jr.** was reassuring: "On the mainland it's true. With the lower humidity, your skin gets dry and starts to itch. . . . We're very fortunate here with our higher humidity. That's why the air feels so good when you step off the plane on returning to Honolulu. It almost seems to caress our cheek." (Sheer poetry. . . .)

The HMA will operate a 2-year project upgrading emergency medical services in the State under a \$1.5 million grant from the RMP. The plans include a state-wide radio communications system connecting ambulance units with hospitals, provide training for ambulance workers, and equip and train workers in the emergency rooms of 20 hospitals. . . .

Scott Halstead, Chairman of the Department of Tropical Medicine and Microbiology at UH, states that more people in Hawaii than on the mainland, of all ages, are susceptible to rubella. A study at the University revealed that 75 to 80% of island-born college women were susceptible, as compared to 10% of women in mainland cities. . . .

The AMA Update surveyed people over age 100 and discovered a common denominator: "An easy-going disposition, a quick sense of humor, and a desire to keep as busy—physically and mentally—as circumstances per-

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mits." **Lee Chau**, of Hilo, attributes his longevity to a rigid time schedule. He goes to bed at 8:00 P.M., rises at 2:00 A.M. and does two hours of yoga and one hour of exercise, then back to sleep for an hour from 5:00 to 6:00 A.M. . . . Methinks he is suffering from insomnia!

Our fighting quaker from Nanakuli, **Mary Glover**, had to appear before the Planning Commission to renew her temporary permit to practice in a residential zone, but she went armed with a long petition signed by local residents. Ever since she "suffered a crisis of conscience" when she worked aboard the hospital ship *Hope* in 1960, Mary has been all over the world, and even now spends her summers working in Watts. . . . There should be more like her. . . .

Bob Rigler swears he overheard a Portuguese woman cautioning her children on the beach with "Watch out for those Japanese Man of War stings, kids!" (From **Eddie Sherman's** column.)

Straub orthopod **Bob Lindberg** feels that the first fracture case of the summer is a mango tree climber, and that oddly enough, it is apt to be an adult, not a kid. Most of the mango tree injuries are wrist injuries. Bob warns, "The mango tree is not to be trusted."

Francis F. C. Wong, prominent Hilo surgeon who passed away last September, left his mark as one of the all-time great sportsmen of Hawaii. An enthusiastic group in Hilo is working on a Doc Wong Scholarship Fund. . . .

Dermatologist **Harry Arnold** warns that *Lyngbya majuscula* is back for the first time in 10 years. He learned that the *Lyngbya* is a seaweed that looks like "tangled, matted blue-green hair in good light and looks black in the water" and causes a very uncomfortable, but not serious burn which heals in 4 or 5 days with ordinary soothing treatment. . . . Harry recommends removing wet bathing suits and showering within ½ hour after a swim as prophylaxis. . . .

Miscellany

"Do you know how Waikiki got its name? Well, when Captain Cook landed on the beach, he found a Chinaman basking under a coconut tree. . . . Captain Cook asked, 'What call ye this place?' The Chinaman replied 'No sabe.' After this dialogue was repeated several times, the Captain was furious and gave the poor man a swift kick in the okole whereupon the surprised Chinaman asked, 'Why kickee?'" (Art Salcedo's 19th hole joke.)

"My wife is a human dynamo." "How's that?" "She goes around charging everything." (From **George Suzuki's** repertoire.)

The boss returned from vacation raring to work. . . . He summoned his pretty secretary and asked how things have been. . . . "Well, I have good news and bad news for you. Which do you want first?" "Oh, no bad news now, please. Just give me the good news." "Well, you're not sterile!" (From **Tom Thorson's** Corner.)

The following is a story of a religious horse. . . . There were something like 21 missions in California in the days of the wild, wild west. . . . A cowboy reached one of these missions after his horse had gone lame. He explained his plight to the mission priest, and the priest offered, "Here take my horse and leave him at the next mission. He's a religious cuss and the only way to control him is to say 'Thank God' to go forward and 'Amen' to stop. The cowboy and the horse got along fine until they came to a 800 foot cliff top. He tugged at the reins frantically without response and just in the nick of time, remembered the priest's words and yelled, "Amen!" The horse stopped at the very brink of disaster. The cowboy swallowed hard, wiped the cold sweat off his brow and said loudly, "Thank God!" (From **Tom Thorson's** Corner.)

"The Cinch Bet"—A woman kept depositing 5 to 10 thousand dollars weekly into her account. The bank

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president became curious and asked, "What do you do for a living?" "I gamble—and I always win." His curiosity further aroused, he asked, "What kind of gambling?" "Well, I'll bet you \$10,000 that you will have 3 testicles by next Monday." "That's ridiculous. . . . I am not a betting man, but to show you how absurd your bets are, I'll take you up on that." Next Monday, the woman came in, accompanied by a well dressed gentleman. The bank president asked confidently, "Are you ready to pay off \$10,000? You lost, you know." The woman admitted, "I guess I lost. . . . But for \$10,000, I think I have a right to check." The banker agreed, and dropped his trousers and shorts, and the woman carefully inspected his testicles for a possible 3rd nugget. . . . Just then the accompanying gentleman fell in a dead faint. "What ails him?" the banker asked. "Oh," she replied, "I bet him \$20,000 that within 5 minutes after we got here, I'd have my hands on your balls." (Harry Arnold, Jr. heard this from a recent Queen's visiting professor.)

Notes on Estate Planning and Incorporation Talks

We were fortunately invited to a joint meeting of the Hawaii Internists Society and Hawaii Surgical Society, held at the Ilikai Imperial Room, to listen to incorporation lawyer **James Conahan** and estate planner **Elliot Loden**. We gleaned the following pearls: James Conahan first turned toward **Gil Freeman** and asked, "Dr. Freeman, 'Is it true that if you don't drink, smoke, and chase women, you live longer?' and Gil replied, 'Not really—it just *seems* longer.'"

Before the Wage Stabilization Act, I would have advised 75% of physicians to incorporate. . . . The following physicians should *not* incorporate just now: The

older physician, in his 60's, and the younger physician whose practice is growing at the rate of 15% per year or more. . . . Under the Economic Stabilization Act, the physician without employees can start at 25% of salary, but for those with employees it would take 4 years to be fully funded. . . .

Elliot Loden's repertoire: "Poor Richard's Almanac says: God heals, and the doctor takes the fee." "All mankind makes love and pays taxes."

The Keogh Plan is taxable on death, whereas in a corporation, the pension plan is not. . . . If real property is in a joint tenancy or tenants in entirety, the full amount is taxable on death, but if it is in tenants in common, only ½ is taxable. . . . The wife has the right to change the trustee at anytime. . . . On life insurance policies, the estate is taxable on death, but if the wife owns the policies, it is not. . . . The 1969 Tax Reform Act is sometimes referred to as the Accountants and Attorney's Relief Act. . . .

Aetna Medicare Review Meeting

A 65-year-old Filipino man was seen twice the same day in the ER and then admitted with the diagnosis: "Tapeworm infestation." Medicare was being charged for the two ER visits and a comprehensive initial hospital visit all on the same day, and moreover a complete reevaluation charge for the next hospital visit. Someone snickered, maybe they thought it was spaghetti coming out the first time." **Dave Flamino**, the visiting director in chief of Aetna Medicare warned, "Careful! We Italians are sensitive to disparaging remarks about spaghetti." Since repeated efforts by the Aetna staff had failed to elicit a reply from the attending physician, the committee recommended allowing only the initial hospital charge, pending a reply.

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Gordon Liu reviewed a case of metastatic breast CA being treated with hypnotherapy at \$35 per visit for intractable pain. John Lowrey whispered, "If it worked, the fee's worth it." A confused clerk had listed the physician's specialty as "Miscellaneous" Plastic man Vic Hay-Roe commented that he uses hypnosis on occasion for his plastic surgery with excellent results. Both Niall Scully and John Lowrey had referred patients for hypnotherapy. Bob Grathwohl, local Aetna medicare director reported that the osteopathic review board had turned down claims for hypnotherapy, but our committee decided that if guidelines could be established, esp. with regard to time involved, it was allowable. . . .

Our medical philosopher Bernie Fong "adjudicated" a case of frequent home calls for a patient originally diagnosed as "angina," who subsequently was found to have gallstones. Bernie was sympathetic: "The patient is apparently confusing the two conditions and calling the physician, so we should allow all the visits." Vic Hay-Roe quipped, "Angina and gallstones. . . . That's a good combination. . . . I'm going to have to remember that. . . ."

Gordon had a case review of a patient with ASHD and fractured ribs who was receiving B₁₂ injections once weekly. The federal guidelines specify that after the initial injection, oral medication should be substituted except in the case of injectable diuretics. The physician wrote back: "The patient is receiving B₁₂ injections, for a case of chronic gastritis which might lead to atrophic gastritis. . . . Atrophic gastritis causes pernicious anemia. . . ." Bernie argued, "What's wrong with that logic?" Bill Dang joked, "He must be Bernie's silent partner." Bernie rebutted, "Yeah, like Uncle Sam."

Allergist Allan Young reviewed a claim for frequent ultraviolet treatments for a skin condition. Vic Hay-Roe, who until recently owned one himself, suggested, "The patient should get a convertible so he can get enough sun on the way to the doctor's office." Allan who had

checked the claim with other dermatologists agreed, "They do better by getting out in the sun." I realize psychotherapy is important, but we should only allow one ultraviolet treatment per week."

Conference Humor

At a Queen's Friday morning conference, Max Botticelli was reviewing the PAR statistics on antibiotic usage for admission pneumonias, and the odious use of drug combinations remained at the same level. . . . Medical director Jim Orbison declared, "As we can see there is no change. . . . The chronic offenders are not at these meetings. . . ." Then, looking at Max, Jim asked, "But you do have a plan?" Max was in a corner, "Makes me look like Kissinger or Nixon. . . . You know, the patient usually gets better whether or not you use antibiotics. . . . It's like a backache. . . . You get better whether you see a physician or a chiropractor. . . ." Bill Sage chimed in: "But now, even chiropractors are pushing that line: We realign your back and you get better on your own. . . ."

When Jim Orbison condemned the use of Lincomycin and advocated erythromycin for bacterial pneumonias. Dan Palmer stated that he agreed erythromycin was preferable, but that Lincomycin was a relatively benign, non-toxic drug. Jim bristled a bit and Dave Andrews piped up, "I have seen a case of severe proctitis from Lincomycin, though this is rare. . . ." Max ad libbed, "Sounds like it is coming from someone who had it."

*Dialogue from a Kuakini Med School
Affiliation Committee Meeting:*

Chief of Staff Henry Oyama minced no words, "Are we a token hospital? How do we stand in the total complex?" Hospital administrator Masa Tasaka added, "Won't affiliation with one large hospital be better for the education of med students? Our program may not



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be too important. . . . We did not even get to submit a grant proposal. . . . And your architects did not even stop by to see me. . . ."

Goodwill ambassador extraordinary, Dean Terry Rogers was at his magnificent best: "You feel short-changed. . . . Why don't we just go to Tripler instead of negotiating with the smaller hospitals? . . . The decision is that of the Governor. . . . He wants the small community hospitals included. . . . Besides this is the most human hospital. . . . There is something at Kua-kini not found in other hospitals. . . . and this is important to medical training. . . . We're interested in a partnership, and not just where you are strong. . . ."

PAS scholar Henry declared, "Historically, with university affiliation, the PAS shows an increase of 2 days of hospital stay. . . ." Terry admitted, "The cost does go up with affiliation. . . . We concede in advance that the day cost will go up with a teaching program. . . ." Henry was worried, "In the actual housekeeping, will a certain number of beds and certain physicians be assigned to team care?" Ken Gardner parried the question with "My philosophy is this. . . . A certain group of physicians like to teach. . . . Another group does not and a third group is in the middle. . . ." Dick Mamiya brought the picture back into focus with the statement that we were already affiliated with the Med School with regard to surgical residency training and that we were simply negotiating an affiliation for med student training. . . . that the assignment of 3rd and 4th year med students will be somewhat proportional to the present quota of surgical residents at the various hospitals. Henry asked, "How much can you service the hospital. . . . This is critical since we may have to supply supplemental help when the interns are gone. . . ." Terry Rogers was firm: "The 4th year medical student will not be a source of labor. If you have to put money in to service the hospital, you should put it in the residency program." To allay the fear that

chiefs of services will be mainland imports rather than local talent, Terry was explicit: "If we can get someone in private practice to take full time positions, it will be a minor triumph." To the question of how much representation on the executive board the Med School wanted, he was diplomatic: "It is not crucial, but it will be a nice gesture if you could invite someone from the medical school to sit on the board." Al Shimamura, expressing the prevailing fear of a med school takeover, asked, "What is the position of the private attendant in team care?" Terry: "He would always be in charge of his patient. The attending physician is the professor, and teacher of the housestaff. He should be qualified to teach in order to admit to team care." On budgetary matters, Terry joked, "The golden rule is: 'He who has the gold rules.'" He further added, "In this affiliation agreement, I urge you not to get hung up on cost factors. . . . We are not insisting the chief be full time, as the site visitors insisted. . . . But in a year's time, you will insist yourselves that he be put on full time. . . ." Knowing well that Terry Rogers had less than two months to respond to the accrediting body, Masa asked, "What is your timetable?" Terry answered, "Like yesterday. . . ." Grant Stemmerman was worried about the wording in the agreement: "The selection and appointment of the chiefs of services in the hospital shall be jointly undertaken by the executive committee and the school of medicine." Stemmy: "I would like a dictionary definition or a university definition of 'jointly undertaken.'" Terry: "Like three from your executive committee and three from the medical school shut up in a room until they come out with a chief."

After the med school trio had left, some of the committee members discussed the possibility of the newly appointed chiefs dictating to the private physicians on the staff. Yutaka Yoshida with characteristic brusqueness reassured the unbelievers: "The chiefs in the old days, if they said, 'Shit!' you *did* shit. . . . That doesn't hold nowadays. . . ."

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Later in the week, we were again impressed by Dean **Terry Roger's** sincere repartee. . . . At the Queen's quarterly, the affiliation matter was being discussed by the pros and cons. . . . Urologist **James Stewart** who advocated a cautious approach "like a shepherd dog approaching a fire hydrant and holding his water" till he had sniffed out the situation. . . . **Terry Rogers** with typical wit commented, "I feel like the fire hydrant with a large shepherd approaching. . . ."

Announcements

PROVOCATIVE ALLERGY COURSE

A practical course in the technique of intradermal provocative food testing and food injection therapy will be offered Saturday and Sunday, March 10-11, 1973, at the Admiral Semmes Hotel, P. O. Box 1209, Mobile, Alabama 36601.

The course will also cover inhalants, chemicals, drugs, fungi, viruses, yeasts, hormones, terpenes, air-pollutants, insects, and contact dermatitis.

The registration fee of \$125.00 also covers one dinner and two luncheons. To register for the course send name, address, and check (payable to Provocative Allergy Course) to: Joseph B. Miller, M.D.; 3 Office Park, Suite 110; Mobile, Alabama 36609.

Room reservations should be made directly with the hotel.

POSTGRADUATE COURSE ON PEDIATRIC PULMONARY FUNCTION AND DISEASE

To be held in New Orleans from Thursday, December 7 through Saturday, December 9, 1972. Course chairman is Will W. Waring, M.D. Sponsors include the American Thoracic Society, the National Cystic Fibrosis Research Foundation, Louisiana State University School of Medicine in New Orleans, Louisiana State University School of Medicine in Shreveport, the Alton Ochsner Medical Foundation, and the Louisiana Thoracic Society.

Complete course outlines, hotel information and registration forms for the Pediatric course are available from W. Findley Raymond, Coordinator, Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130.

POSTGRADUATE COURSE ON PULMONARY FUNCTION IN HEALTH AND DISEASE

To be held in New Orleans, Monday, December 4 through Thursday, December 7, 1972. Sponsored by the American Thoracic Society, Tulane University School of Medicine, Louisiana State University School of Medicine in New Orleans, and the Alton Ochsner Medical Foundation, the course has as its administrative sponsor, the Louisiana Thoracic Society.

Course programs, application forms and hotel information are available from the Louisiana Thoracic Society, suite 1504, 333 St. Charles Avenue, New Orleans, La. 70130; Attention: W. Findley Raymond, Course Coordinator.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION SCIENTIFIC ASSEMBLY

The 57th Annual Scientific Assembly will be held at the Washington-Hilton Hotel, Washington, D.C., November 13-16, 1972. For additional information write: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P. O. Box 5445, Madison, Wisconsin 53705.

AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY ANNUAL MEETING

The American Electroencephalographic Society and The American Society of Electroencephalographic Technologists will hold their 1972 Annual Meetings at the Shamrock Hilton Hotel in Houston, Texas October 12th

through 14th. For additional information write: Mrs. Margaret H. Henry, Executive Secretary, The American EEG Society, 36391 Maple Grove Rd., Willoughby Hills, Ohio 44094.

AMERICAN COLLEGE OF CHEST PHYSICIANS

Will hold their 38th Annual Scientific Assembly October 23-26, 1972 at the Denver Convention Complex, Denver, Colorado. For additional information write: American College of Chest Physicians, 112 E. Chestnut St., Chicago, Illinois 60611.

AMERICAN COLLEGE OF PHYSICIANS 1972-73 POSTGRADUATE COURSES

These courses are arranged through the cooperation of the directors and the institutions involved. Registration forms and requests for information are to be directed to: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

September 25-29, 1972

BASIC MECHANISMS IN INTERNAL MEDICINE

Medical College of Virginia, Div. of Health Sciences, Richmond, Va.

October 2-4, 1972

CURRENT CONCEPTS IN HEMATOLOGY

University of Pittsburgh School of Medicine, Pittsburgh, Pa.

October 2-4, 1972

DEVELOPMENTAL BIOLOGY AND PERINATAL MEDICINE

McGill University, Montreal, Que., Can.

October 2-6, 1972

THE NON-MEDICAL USE OF DRUGS: CHALLENGE TO THE PHYSICIAN

New Jersey College of Medicine, Newark, N. J., to be held at the Downtowner Hotel, Newark, N. J.

October 9-11, 1972

ADVANCES IN THERAPEUTICS AND CLINICAL PHARMACOLOGY

Reitz Union, University of Florida, Gainesville, Fla.

October 9-12, 1972

HUMAN REPRODUCTION, POPULATION PROBLEMS AND FERTILITY CONTROL

Harvard Medical School, Boston, Mass.

October 12-14, 1972

RECENT ADVANCES IN INFECTIOUS DISEASES

A Tribute to Dr. Wesley W. Spink; Mayo Mem. Aud., University of Minnesota, Health Sciences Center, Minneapolis, Minn.

November 6-8, 1972

CURRENT AND FUTURE CONCEPTS IN GASTROENTEROLOGY

Univ. of Arizona College of Medicine, Tucson, Ariz.

November 8-10, 1972

INTERNAL MEDICINE GRAND ROUNDS

Mayo Clinic, Rochester, Minn.

November 15-17, 1972

IN-VITRO STUDIES IN NUCLEAR MEDICINE

The Johns Hopkins Medical Institution, Baltimore, Md.
December 4-8, 1972

ADVANCES IN DIAGNOSIS AND TREATMENT IN CLINICAL MEDICINE

Disneyland Hotel, Anaheim, Calif.; Co-sponsored by UCLA School of Medicine, Dept. of Internal Medicine, Los Angeles, Calif., with affiliated hospitals—Harbor General Hosp., Torrance, Calif., St. Mary's Long Beach Hospital, Long Beach, Calif.

January 8-10, 1973
THREE DAYS OF LIVER DISEASE
Woodruff Medical Center of Emory University, Atlanta, Ga., to be held at Royal Coach Motel, Atlanta, Ga.

February 8-10, 1973
RECENT ADVANCES IN THE IMMUNOPROPHYLAXIS AND CHEMOTHERAPY OF INFECTIOUS DISEASES
University of Arizona College of Medicine, Tucson, Ariz.

February 26-March 2, 1973
CLINICAL GASTROENTEROLOGY
University of Michigan Medical Center, Ann Arbor, Mich.

March 5-8, 1973
PROBLEMS OF INTERNATIONAL HEALTH
Co-sponsored by the Naval Department, to be held at LeBaron Hotel, San Diego, Calif.

March 5-8, 1973
MODERN NEUROLOGICAL DIAGNOSIS AND THERAPY
University of Miami School of Medicine, Miami, Fla., to be held at the Eden Roc Hotel, Miami, Fla.

March 12-16, 1973
INFECTIOUS DISEASES
University of Maryland School of Medicine, Baltimore, Md.

March 14-16, 1973
CLINICAL PHARMACOLOGY: RATIONAL BASIS OF THERAPEUTICS
Univ. of California School of Medicine, San Francisco, Calif.

March 19-23, 1973
FOUR AND ONE-HALF DAYS OF INTERNAL MEDICINE: WHAT'S NEW?
University of Alabama School of Medicine, Birmingham, Ala.

March 22-24, 1973
CLINICAL RECOGNITION AND MANAGEMENT OF HEART DISEASE—1973
University of Arizona Medical Center, Tucson, Ariz.

March 26-30, 1973
CARDIOLOGY—1973—TOPICS OF CURRENT INTEREST
Mount Sinai School of Medicine, New York, N. Y., to be held at the Americana Hotel, New York, N. Y.

April 4-6, 1973
RECENT ADVANCES IN DIAGNOSIS AND MANAGEMENT OF PULMONARY DISEASE
Virginia Mason Medical Center, Seattle, Wash.

April 24-27, 1973
PULMONARY DISEASE
University of Pennsylvania School of Medicine, Philadelphia, Pa.

April 25-27, 1973
HEPATOBIILIARY DISEASE IN CLINICAL PRACTICE
Co-sponsored by Presbyterian Hospital of Pacific Medical Center and the Department of Gastroenterology, University of California, San Francisco, to be held at the Hilton Hotel in San Francisco, Calif.

April 25-27, 1973
ADVANCES IN DIAGNOSIS AND MANAGEMENT OF INFECTIOUS DISEASE
University of Wisconsin, Madison, Wis.

May 16-18, 1973
THE RHEUMATIC DISEASES—CLINICAL AND IMMUNOLOGICAL ASPECTS
University of Texas Southwestern Medical School, Dallas, Tex.

May 16-18, 1973
CLINICAL AUSCULTATION OF THE HEART
Georgetown University Hospital, Washington, D. C.

May 21-25, 1973
INTERNAL MEDICINE: CURRENT CONCEPTS OF CLINICAL PROBLEMS
University of Cincinnati Medical Center, Cincinnati, Ohio.

May 21-25, 1973
INTENSIVE CARE UNITS
St. Vincent's Hospital and Medical Center of New York, New York, N. Y.

May 29-June 1, 1973
RECENT ADVANCES IN ENDOCRINOLOGY AND THEIR CLINICAL APPLICATIONS
Royal Victoria Hospital, Montreal, Que., Can.

June 4-8, 1973
HEMATOLOGY
University of Washington School of Medicine, Seattle, Wash.

June 13-15, 1973
ONCOLOGY AND CHEMOTHERAPY
University of Southern California, Los Angeles, Calif.

June 18-22, 1973
CLINICAL ASPECTS OF BLOOD TRANSFUSION
Michigan State Univ., East Lansing, Mich., to be held at the Kellogg Center for Continuing Education.

June 25-29, 1973
ADVANCES IN INTERNAL MEDICINE: RECENT PERSPECTIVES, 1973
To be presented at the Banff School of Fine Arts, Banff, Alta., Can.; Co-sponsored by The University of Alberta Medical School at Edmonton, The University of Calgary Medical School, The American College of Physicians and the Royal College of Physicians and Surgeons of Canada.

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Dosage: 1 or 2 tablets daily, as indicated by clinical need.

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* Grade II diabetic retinopathy is revealed
by the small hemorrhages and exudates
in this photograph of the fundus.

A CASE FOR "500"



BRIEF SUMMARY

(For full prescribing information, see package circular.)

GRISACTIN® [griseofulvin (microsize)]

Indications: Griseofulvin is indicated for the treatment of ringworm infections of the skin, hair, and nails, namely: *Tinea corporis*, *Tinea pedis*, *Tinea cruris*, *Tinea barbae*, *Tinea capitis*, *Tinea unguium* (onychomycosis) when caused by one or more of the following genera of fungi: *Trichophyton rubrum*, *T. tonsurans*, *T. mentagrophytes*, *T. interdigitalis*, *T. verrucosum*, *T. megnini*, *T. gallinae*, *T. crateriform*, *T. sulphureum*, *T. schoenleini*, *Microsporum audouinii*, *M. canis*, *M. gypsum*, *Epidermophyton floccosum*.

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following: Bacterial infections, candidiasis (moniliasis), histoplasmosis, actinomycosis, sporotrichosis, chromoblastomycosis, coccidioidomycosis, North American blastomycosis, cryptococcosis (torulosis), *tinea versicolor*, nocardiosis.

Contraindications: This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of hypersensitivity to griseofulvin.

Warnings: *Prophylactic Usage*—Safety and efficacy of griseofulvin for prophylaxis of fungal infections has not been established.

Animal Toxicology—Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally ad-

ministered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy—The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies—It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

Precautions: Patients on prolonged therapy with any potent medication should

GRISACTIN[®] 500 Tablets

Brand of
griseofulvin (microsize)



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be under close observation. Periodic monitoring of organ system function, including renal, hepatic, and hematopoietic, should be done.

Since griseofulvin is derived from species of penicillin, the possibility of cross-sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

Adverse reactions: When adverse reac-

tions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

Dosage and administration: Accurate diagnosis of the infecting organism is essential. Medication must be continued until the infecting organism is completely eradicated as indicated by ap-

propriate clinical or laboratory examination. General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required, particularly in treatment of *tinea pedis*.

Dosage should be individualized, depending on age and severity of infection. *Adults*—0.5 Gm. daily (125 mg. q.i.d., 250 mg. b.i.d., or 500 mg./day). *Children*—10 mg./kg. daily is usually adequate (from 30 to 50 lb., 125 mg. to 250 mg. daily; over 50 lb., 250 mg. to 500 mg. daily, in divided doses.)

How supplied: GRISACTIN [griseofulvin (microsize)]—No. 442—GRISACTIN 125, each capsule contains 125 mg., in bottles of 100 and 500. No. 443—GRISACTIN 250, each capsule contains 250 mg., in bottles of 100 and 500. No. 444—GRISACTIN 500, each tablet (scored) contains 500 mg., in bottles of 60.

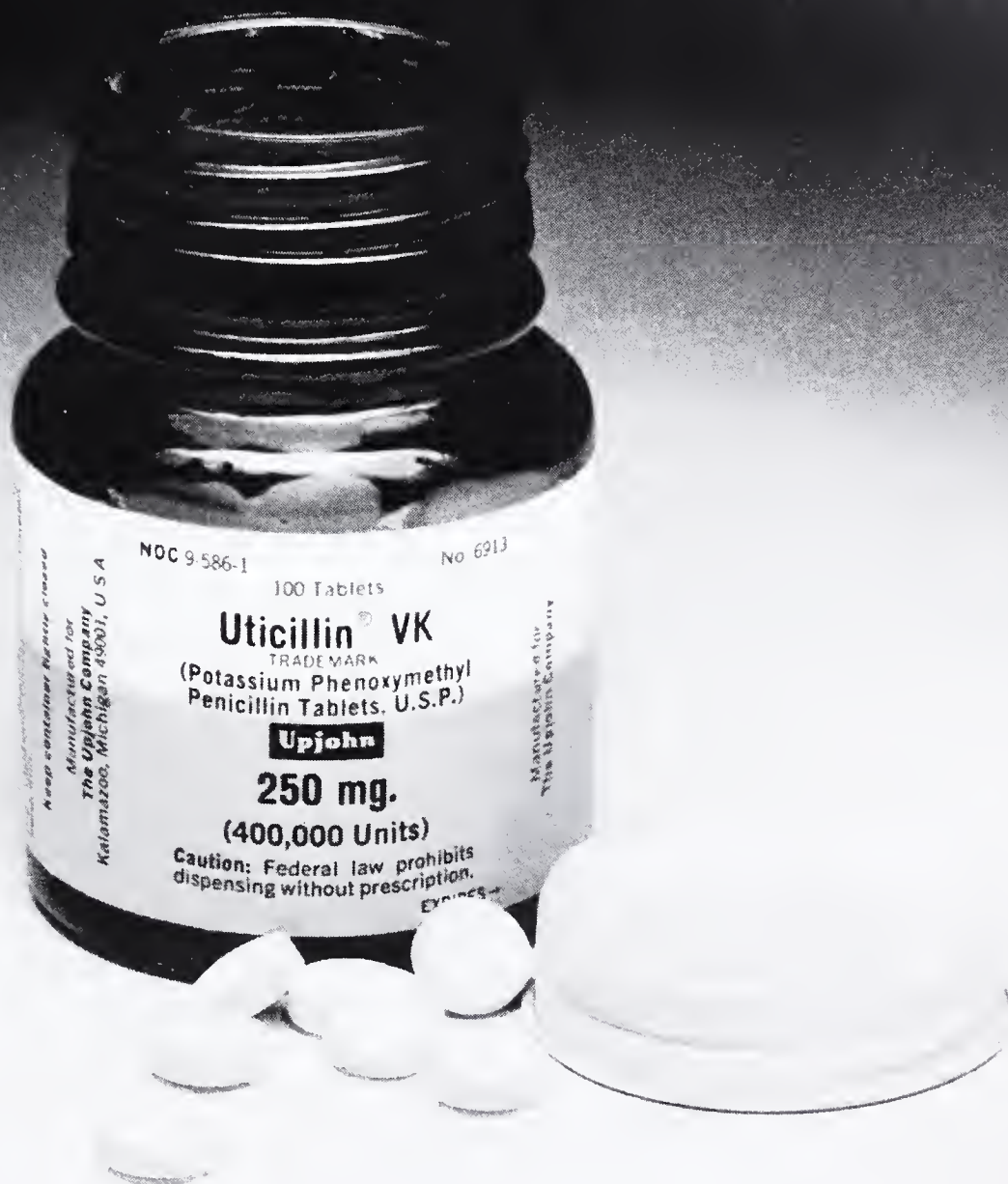
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NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical aftercare, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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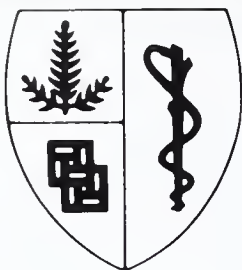


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(erythromycin, Upjohn)
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Upjohn

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October 30, 31, November 1, 2, 3, 1972

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Respiratory failure: Part I, Pathophysiology; Part II, Manifestations. Controlled oxygen therapy, assisted and controlled ventilation; Part III, Management of reversible factors; Thromboembolism.

Acute renal failure; Hyper- and hypokalemia; Diabetic ketoacidosis and hyperosmolar coma; Adrenal crisis.

Mechanisms of hemostasis; Management of hereditary disorders of coagulation; Disseminated intravascular coagulation; Transfusion of blood and its components.

Gram-negative sepsis; Oncologic emergencies; Cerebral death; Infections in the compromised host.

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Pulmonary function testing and arterial puncture; Use of mechanical ventilators; Respiratory distress in the newborn.

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October 30, 31, November 1, 2, 3, 1972

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**for
today's
pain...**

**memory of
yesterday's
pain...**

**apprehension over
tomorrow's
pain—**

the analgesic formula that calms instead of caffeinates

Phenaphen[®] with

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

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HAWAII MEDICAL JOURNAL

VOLUME 31 / NUMBER 6





rheumatoid arthritic blowup... Tandearil® Geigy oxyphenbutazone NF

tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. **Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis. **Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy. **Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonamides, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis or may not be prominent), petechiae, purpura with thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with multiple necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement. (B) 98-146-800-E

For complete details, including dosage, please see full prescribing information.

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or open to infection...
choose the topical
that gives your patient—**

**broad antibacterial activity against
susceptible skin invaders
low allergenic risk—prompt clinical response**

Special Petrolatum Base
Neosporin[®] Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate, 5000 units;
Zinc bacitracin, 400 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg.
neomycin base); special white petrolatum q. s.
in tubes of 1 oz. and ½ oz. for topical use only.

NEOSPORIN for topical infections due to susceptible organisms, as in
impetigo, surgical aftercare, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may
result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate
measures should be taken if this occurs. Articles in the current medical
literature indicate an increase in the prevalence of persons allergic to
neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is
perforated. This product is contraindicated in those individuals who
have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.



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Will his return to work mean the return of undue psychic tension?



When it's mandatory to keep the post-coronary patient calm, consider Valium (diazepam).

Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. If he experiences excessive anxiety and tension because of overreaction to stress, your prescription for Valium can bring relief. During the period of readjustment Valium can quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety

states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

Valium® (diazepam)

For the tense cardiac patient who must be kept calm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg *b.i.d.* to *q.i.d.*; alcoholism, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d.* **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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HAWAII MEDICAL JOURNAL

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included abdominal pain, nausea, vomiting and diarrhea or loose stools. In a few instances, diarrhea lasted for several days; one case of bloody stools was reported. *Hematopoietic:* Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported. *Skin and Mucous Membranes:* Skin rash and urticaria have been reported infrequently. *Hypersensitivity Reactions:* A few cases of hypersensitivity reaction have been reported. If hypersensitivity occurs, discontinue drug and have available the usual agents (epinephrine, corticosteroids, antihistamines) for emergency treatment. *Liver:* Although no direct relationship of Cleocin HCl (clindamycin HCl hydrate) to liver dysfunction has been noted and significance of such change is unknown, transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminases) have been observed in a few instances. Also, abnormal liver function test values at the beginning of therapy have returned to normal during therapy.

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Some Adverse Health Effects Due to Air Pollution from Fireworks

WILFRID BACH, Ph.D., LOUIS DICKINSON, M.D., Dr. P.H.,
BETSY WEINER, M.D., and GWEN COSTELLO, B.S., *Honolulu*

In Hawaii, asthma and hay fever occurred with a 1.3 times greater prevalence than on the Mainland in 1958. More recently, respiratory diseases are increasing at an unusually rapid rate in Hawaii. The impact on health of high air pollution concentrations from a New Year's fireworks episode was investigated to obtain further insight into any causal relationships.

Air pollutants of particle sizes small enough to penetrate deeply into the lungs were measured with a nephelometer. During the fireworks episode the suspended particulate level in Palolo Valley was at least 20 times above the normal concentration. Relevant meteorological surface and upper air data were obtained. All records from five Honolulu hospital emergency rooms were inspected. Eleven diseases were abstracted and grouped into chronic respiratory disease and coronary heart disease. The Poisson distribution was used to determine statistically significant differences between the episode and a control period.

It was found that chronic respiratory disease among adults more than doubled during the fireworks episode. Such confounding variables as age, sex, social class, smoking habits, changes in total population, weather elements, volcanic emissions, auto exhausts, pesticides, pollen, etc. were examined and dismissed as factors unlikely to have caused the increased respiratory illness. Alcohol remained as a possible confounding factor, but is presently not considered as an important cause of respiratory disease.

It would therefore appear that the very high air pollution levels during the fireworks episode might have been responsible for the higher occurrence of respiratory diseases. It is recommended to display fireworks only along the Waikiki coastline to protect a large segment of the Honolulu populace from adverse health effects.

EVERY YEAR the islands of Hawaii experience a display of New Year fireworks. Introduced to the islands by its Chinese populace, the fireworks are used to chase away evil spirits and are said to be an expression of gratitude for an affluent year. According to the *Sunday Star-Bulletin and Advertiser* of January 2, 1972, fireworks dealers reported the sale of more than \$1 million worth of fireworks for the 1971-72 New Year's celebration.

On New Year's Eve and New Year's day the display of fireworks is legal in Hawaii between specified time periods and on private property. The display of aerial fireworks and the explosion of firecrackers on sidewalks and public streets is illegal. The Honolulu Police Department arrested 41 adults and 3 juveniles for such fireworks violations over New Year.

The most noticeable side effects of the fireworks were those caused by air pollution and noise. Many citizens with respiratory and heart ailments barricaded themselves behind closed windows and doors only to find that the unbreathable mixture of sulfur and nitrogen oxides, carbon monoxide, and fine smoke particles could not be prevented from penetrating inside.

It is now well accepted that episodes of air pollution are associated with more frequent occurrence of asthmatic attacks, typically affecting adults with a history of the disease. Such outbreaks of asthma occurred in the cities of Los Angeles,¹ Minneapolis,² New Orleans,³ and Tokyo-Yokohama.⁴ In children, hospital admission rates for asthma have been related to the moderate levels of particulate air pollution prevailing in their neighborhoods.⁵ The effects of air pollution on chronic bronchitis, emphysema, and coronary heart disease have been well reviewed elsewhere.^{6, 7}

In Hawaii, asthma and hay fever are unusually common, occurring with 1.3 times greater preva-

lence than on the Mainland in 1958 (72 versus 54 per 1000 population).⁸ Furthermore, our rates for these diseases are increasing rapidly, reaching a level in 1964-1967 that was 1.4 times greater than previously (99.4 per 1000).⁹ There is similar evidence from mortality data that the health of our lungs is deteriorating at an unusually rapid rate: Hawaii's mortality from acute and chronic bronchitis increased by 2.3 times during the period 1960-1967 (0.9 to 2.1 per 100,000) as compared with a 1.3-fold rise for the whole United States (2.4 to 3.2 per 100,000).¹⁰

This extraordinary time trend points to causal factors other than the stable tropical flora common in our environment. Such factors may include the use of pesticides,¹¹ atmospheric pollution, other agents, and interactions among them all. The display of fireworks over such a large geographic area, at such a multitude of sources, and affecting so many people is certainly worthy of a detailed investigation. In this report, the episode of air pollution from fireworks is related to those meteorological conditions which might have aggravated the air pollution effects, and to chronic respiratory and coronary heart disease.

METHODS AND DATA COLLECTION

Meteorological

Whether air pollution concentrations from fireworks at times reach very high values is to a large extent governed by the prevailing weather. Certain meteorological conditions in combination with air pollutants and other factors may have adverse effects on the health and well-being of people. For this reason meteorological elements pertinent to such a study have to be analysed.

The analysis of hourly and daily surface data included wind speed and direction, temperature, and relative humidity. The Experiment Station of the Hawaii Sugar Planters Association at Makiki was selected as the most representative site for the Honolulu urban area. Visibility and the vertical variation of wind speed and direction were analysed at the Honolulu International Airport (HIA), the only recording station that takes such readings. The vertical wind data were obtained from pilot balloon ascents made 4 times a day at 2, 8, 14, and 20 hours, HST. The vertical temperature variation, an index of the stability of the air, was evaluated for Hilo Airport, the closest station to Honolulu that makes such measurements. Radiosonde ascents that supply the vertical temperature data are made twice a day, at 2 and 14 hours, HST.

Air Pollution

A nephelometer, a light-scattering device that measures particles 0.2 to 2.0 μm in diameter, was used to assess the concentration of suspended smoke particles in the air during the fireworks episode. The mechanism of this instrument and the results obtained with this equipment have been discussed elsewhere.^{12, 13} The instrument was mounted on a station wagon with the air intake stretching out of a window at breathing level. The instrument was exposed in Palolo Valley (Pakui St.) from 8 p.m. on December 31, 1971, through 5 p.m. on January 1, 1972. The fireworks activities were monitored continuously on chart paper. Since the instrument was set to measure a maximum value of 380 $\mu\text{g}/\text{m}^3$ of suspended particulates, and since the recorder went off the scale several times during the peak firecracker activities, the absolute highest pollution concentrations have not been measured.

In addition to the continuous suspended particulate measurements, we have analysed data of 24-hour suspended particulates, 3-hour photochemical oxidants, and 1-hour carbon monoxide. These data were collected by the Department of Health (DOH) at their Punchbowl building. They constitute the only semi-continuous recordings in Honolulu. Unfortunately no measurements were made over the holiday periods. Therefore these data can only give some indication of the air pollution level in Honolulu, but cannot be used in the statistical analyses.

HEALTH EFFECTS

All of the records from five Honolulu hospital emergency rooms were inspected for the period December 22, 1971 to January 4, 1972, and abstracted if any of the following diseases were mentioned: (1) bronchitis, unqualified, ICDA 490; (2) chronic bronchitis, ICDA 491; (3) bronchiectasis, ICDA 518; (4) asthma, ICDA 493; (5) emphysema, ICDA 492; (6) congestive heart failure, ICDA 427.0; (7) angina pectoris, ICDA 413; (8) acute myocardial infarction, ICDA 410; (9) coronary insufficiency, ICDA 411; (10) cardiac arrhythmias, ICDA 427.3-427.9; (11) sudden death, ICDA 795.

In this list the 8th Revision of the International Classification of Diseases, Adapted¹⁴ was used. Records mentioning congestive heart failure in connection with hypertension alone were excluded. These diseases were further grouped into "chronic respiratory disease" (items 1-5 above) and "coronary heart disease" (items 6-11 above). In order

to retain the counting of *individuals* in spite of grouping diagnoses, when several respiratory or heart diseases were mentioned, only one was counted. For example, cardiac arrest + myocardial infarction = myocardial infarction (there were 8 of these), chronic bronchitis + emphysema = chronic bronchitis (there were 5 of these), and asthma + emphysema = asthma (there were 5 of these).

The days of observation were grouped into four comparison periods: (1) study period, December 31 to January 2; (2) control period, December 24 to December 26; (3) period three, December 29 to December 30, and January 3 to January 4; and (4) period four, December 22 to December 23 and December 27 to December 28. This grouping was designed to take into account (1) the period of exposure and (2) the day of the week, which would have an important effect on number of emergency room visits. During the 14-day observation period the usual hospital outpatient departments were closed on December 24 to December 26 and December 31 to January 2, thereby increasing the utilization of the emergency rooms. This effect would be especially pronounced for asthma patients, who are most often seen in regular outpatient clinics. The chosen grouping of days insures that all comparison periods have comparable days included.

The hypotheses of the study may be stated as follows: First, the study period should have more illness than the control period, beyond that expected from chance. Second, period three and period four, which surround the study and control periods, should *not* differ in illness beyond that expected from chance. For the second hypothesis to be valid, there should be no lag effects of the air pollution beyond the second day. This has generally been found to be true in previous studies.¹⁵

Since the cases collected during the 14 days of observation represent very small disease incidence rates in the total population, the numbers of cases are treated as Poisson variables in the statistical analysis. That is, their expected variability (standard deviation) is approximately equal to the square root of the observed value.¹⁶ For convenience, the 95% and 99% confidence intervals of the observed values (ie, ± 1.96 and 2.58 standard deviations) were determined by reference to published tables.¹⁷ If the 95% confidence intervals around two values do not overlap, the difference between the two values is said to be significant at the .05 level. If the confidence intervals do overlap, the differences are said not to be statistically significant.

Meteorological and Air Pollution

Figure 1 gives a composite picture of the air pollution and meteorological conditions during the fireworks episode from 8 p.m. on December 31, 1971 to 5 p.m. on January 1, 1972. At 8 p.m., when the recording started, the suspended particulate level was already at about $130 \mu\text{g}/\text{m}^3$ despite the fact that firecracking appeared to be only sporadic. This concentration was about 5 times higher than that found on a typical day in the Palolo Valley. Shortly after 8 p.m. with increased fireworks activities the nephelometer went off the scale for the first time recording higher than $380 \mu\text{g}/\text{m}^3$. These high pollutant concentrations were entirely due to fireworks, because there are no other pollution sources in this neighborhood, and also Madam Pele was inactive throughout the whole period; besides, the wind was not blowing from the Big Island toward Oahu.

Very light surface winds of 2 mph and less were highly conducive to a build-up of pollutants near the ground. The vertical wind data taken over the HIA reported light trade winds within a shallow inversion layer near the ground.

At about 11 p.m. the pollution level dropped from off-scale to about $100 \mu\text{g}/\text{m}^3$. This was apparently the rest before the big storm which was used to refill the ammunition depots. With the big New Year bang the recording pin jumped promptly off-scale again and stayed off the scale for almost two solid hours.

The vertical temperature data recorded over Hilo at 2 a.m. show a shallow surface inversion. Comparing the full extent of the 2 a.m. temperature sounding on January 1 with the dry adiabatic lapse rate (DALR) one can see that the air mass was fairly stable over Hilo up to a height of almost 6 km.

The visibility observed at HIA decreased significantly, starting at 10 p.m. and reaching its lowest value of 6 miles at 1 a.m. At certain locations the visibility was practically zero. The temperature during the fireworks episode was a constant 60°F accompanied by a high relative humidity of a persistent 90%.

The surface wind conditions at 2 a.m. were much the same as on the previous evening at 8 p.m. The vertical wind speed up to a height of about 500 m increased slightly, however, which may have helped to decrease the pollution level after 2 a.m. But there is no doubt that the 13-fold decrease in the pollution level starting at about 2 a.m. was the result of slackening of fireworks activities.

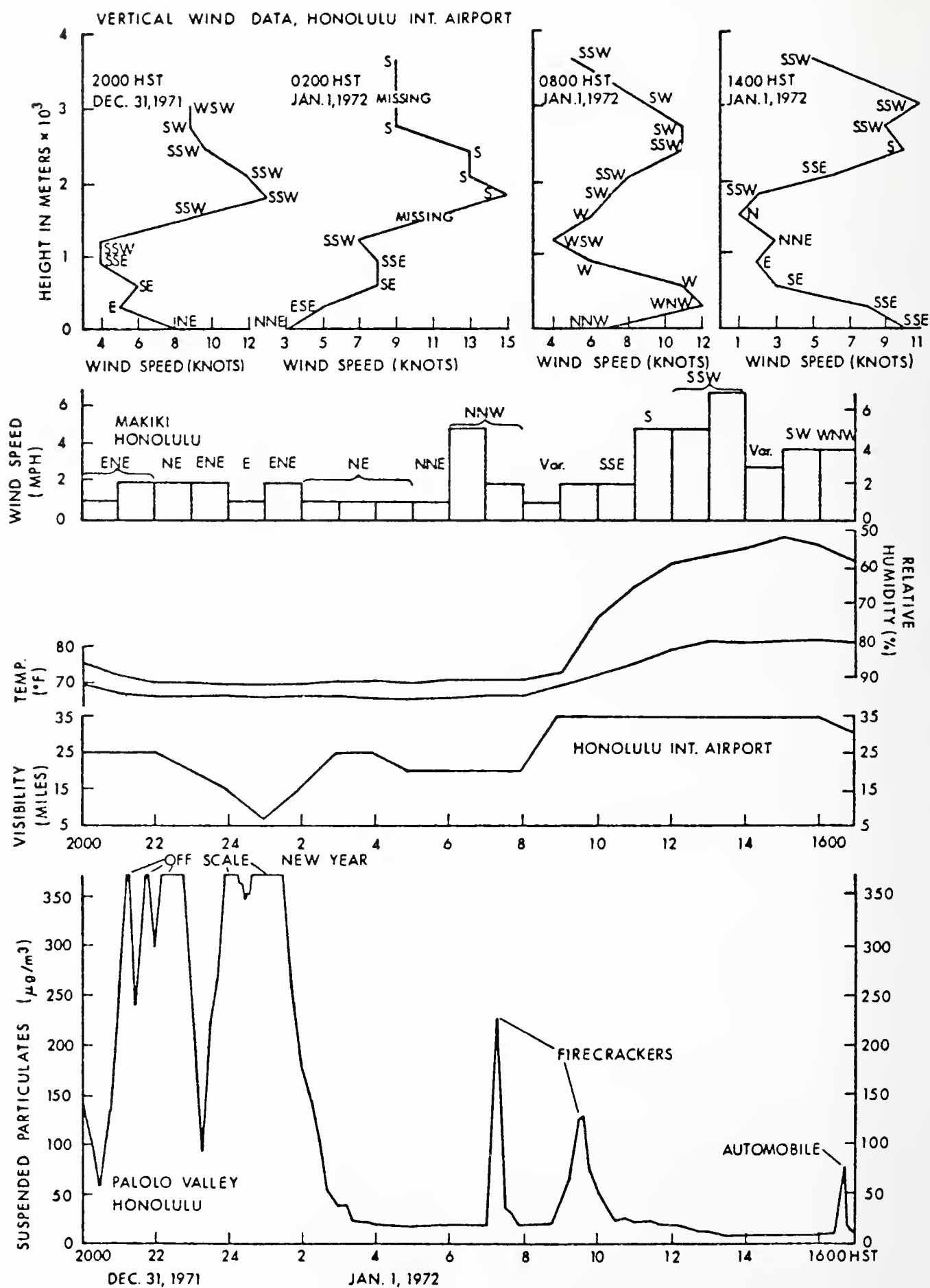


FIG. 1.—Air pollution and weather over the New Year period of 1971-72 in Honolulu.

At 7:15 a.m. and at 9:30 a.m. the nephelometer recorded two more isolated episodes of fireworks, probably caused by people who had too large a supply, or who were annoyed by the big bang during the night and now had their revenge. At 4:45 p.m. an automobile passed closely by the instrument, leaving behind a pollution trail of the order of 75 $\mu\text{g}/\text{m}^3$. Although this value was about 5 times above the afternoon background value of 15 $\mu\text{g}/\text{m}^3$, it was still at least 5 times below the pollutant concentrations caused by the fireworks. The low afternoon concentrations were due to the cessation of the fireworks and the increased wind speeds from variable directions oscillating between SSW and WNW. From 9 a.m. on January 1, 1972, continuing through the day the HIA reported the usual visibility of equal or greater than 35 miles.

Illness Study

A total of 412 patients visited the five Honolulu hospital emergency rooms during the 14-day observation period for the 11 selected illnesses. These visits were distributed by hospital as follows: 91 at Kaiser, 106 at Queen's, 72 at St. Francis, 34 at Kuakini and 113 at Children's. The age distributions of the patients are presented in Table 1. As would be expected, large numbers of children were affected by chronic respiratory diseases, and coronary heart diseases affected only adults. The sex ratio (male : female) of the respiratory disease patients was 1.4 to 1, and for those with heart disease was 1.9 to 1.

TABLE 1.—Age distributions of patients visiting Honolulu emergency rooms for chronic respiratory and coronary heart diseases, December 22, 1971 to January 4, 1972.

AGE	CHRONIC RESPIRATORY DISEASE	CORONARY HEART DISEASE
0-4	73	0
5-9	46	0
10-14	40	0
15-19	38	0
20-29	52	2
30-39	33	4
40-49	16	9
50-59	17	12
60-69	19	12
70-79	17	12
80-89	2	4
90-99	3	1
TOTAL	356	56

In the grouping of chronic respiratory diseases, 305 out of 356 (86%) had the diagnosis of asthma. In the grouping of 56 coronary heart disease patients, 23 (41%) had acute myocardial

infarction, 12 (21%) had cardiac arrhythmias, and 10 (18%) had angina pectoris.

In Table 2 the numbers of emergency room visits are shown for the four comparison periods.

TABLE 2.—Emergency room visits for chronic respiratory and coronary heart diseases, by age and time period, with 95% confidence intervals in parenthesis; December 22, 1971-January 4, 1972.

AGE AND PERIOD*	CHRONIC RESPIRATORY DISEASE	CORONARY HEART DISEASE
Age 0-14		
Study period	43 (31-58)	0
Control period	58 (44-75)	0
Period three	20 (12-31)	0
Period four	38 (27-52)	0
TOTAL	159	0
Age 15-99		
Study period	68 (53-86)†	8 (3-16)
Control period	32 (22-45)†	19 (11-30)
Period three	40 (29-54)	15 (8-25)
Period four	57 (43-74)	14 (8-23)
Total	197	56
TOTAL, all ages	356	56

* Study period = 12-31, 1-1 and 1-2; Control period = 12-24, 12-25 and 12-26; Period three = 12-29, 12-30, 1-3 and 1-4; Period four = 12-22, 12-23, 12-27 and 12-28.

† The difference between 68 and 32 is significant at the .05 level.

Among adults (age 15-99), the visits for chronic respiratory disease occur as the hypothesis would predict if air pollution is causally related to these illnesses: the pollution period had 68 visits as compared with 32 in the control period. This two-fold increase in risk is statistically significant at the .05 level. Indeed, since the 99% confidence intervals for 68 are 49-92 and for 32 are 19-50, this difference is very nearly significant at the .01 level. Periods three and four do not differ significantly from each other, in further support of the stated hypothesis. In fact, no lag effects from the pollution episode were at all detectable in period three.

In Figure 2 the respiratory disease visits for adults during the pollution period are depicted as a ratio in comparison with the same day the previous week. For the week beginning December 29, these ratios are as follows: 13/16, 9/17, 14/4, 27/15, 27/13, 13/15 and 5/9. With the onset of the fireworks episode respiratory disease visits for adults increased more than three fold and stayed high for a few days. Air pollution data over this period were not available. But the wind speed had decreased which might have been conducive to higher pollution levels. Temperature and relative humidity could not be the decisive factors, because they were the same throughout the study and the control period.

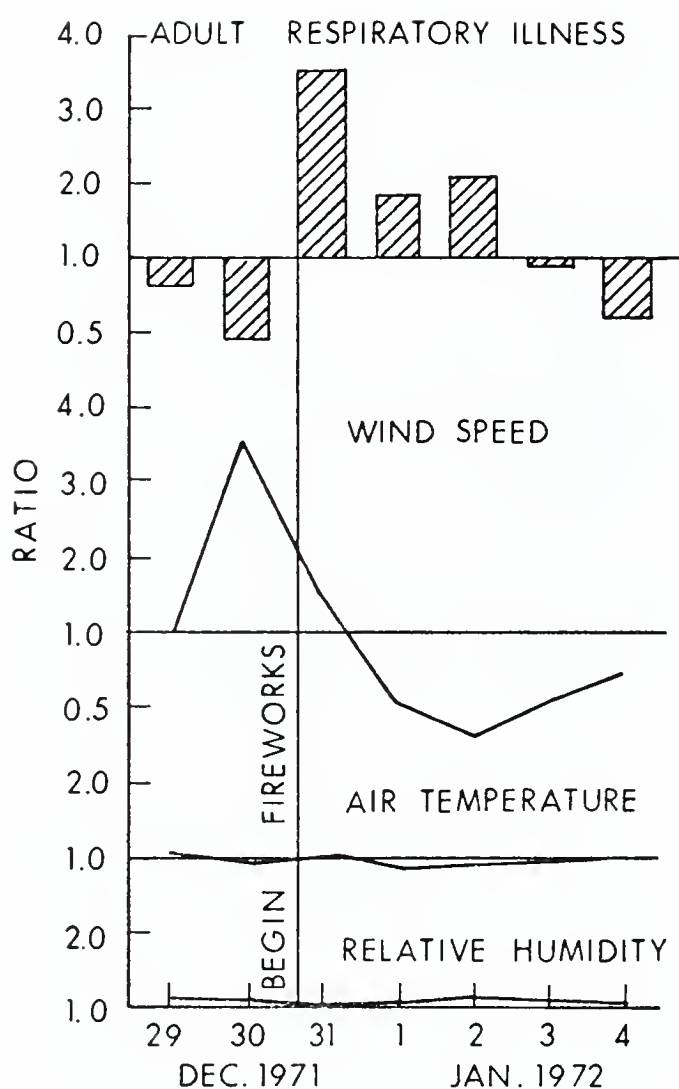


FIG. 2.—Adult respiratory illness and meteorological elements during the episode in comparison with the same day the previous week.

None of the remaining hypotheses were confirmed. There were no statistically significant differences in visits for chronic respiratory disease among children or for coronary heart disease among adults. Most unexpectedly, the children appeared to have increased risk from respiratory diseases (mostly asthma) during the Christmas period—a finding which will be discussed subsequently. The Christmas holiday also seemed to be somewhat more risky for adults with coronary heart disease.

All Oahu death certificates for the 18-day period December 20, 1971 to January 6, 1972 were scrutinized for the same illnesses listed previously. Altogether there were 17 deaths in the chronic respiratory disease category and 65 in the coronary heart disease grouping. There were no patterns by day of month which could possibly be related to the air pollution episode, and the mortality data will not be presented in more detail.

There were 19 fireworks injuries serious enough to require emergency room treatment, 12 among children (age 0-14) and 7 among adults (age 15-99). Most of these injuries were burns, and none was severe enough to require hospitalization.

DISCUSSION OF RESULTS

Although a doubled risk of chronic respiratory illness among adults during the air pollution episode is a rather large increase, the ratio is still not so large that we can be absolutely confident that it was not a spurious association related to other variables. That is, we must look carefully to see if the statistical association could really be a causal one.

In studies examining possible causal relationships between air pollution and health, the most important confounding variables that must be considered are age, sex, smoking habits, social class and weather. These variables are known to be associated both with air pollution and health.

In this study, it is unlikely that during the 14 days of observation there were major changes in the age, sex, social class and smoking habits of the Oahu population. The weather variables, as described earlier in this report, were rather constant. In fact, for the study and control periods respectively, the average temperatures ($^{\circ}\text{F}$) were 70.8 and 71.0, and the average relative humidity values (%) were 78.7 and 75.7. In studies which have shown associations between temperature and humidity and respiratory disease, the fluctuations of the weather variables were much greater than these.¹⁸

It is not quite so reasonable to assume that the total population of Oahu did not change during the period of observation. Since large numbers of people can be accommodated in the resort hotels, marked fluctuations in occupancy rates could materially affect the total population at risk. It was possible to obtain information on number of units, occupancy rates, and guests/unit for the study and control periods. The values for these (in the order given) were 25,112, 89.2%, and 2.05 for the study period and 25,112, 65.5%, and 2.03 for the control period. Calculation with these figures indicates that there were approximately 12,500 additional people present in the study period as compared with the control period. This represents about a 2% increase in the total population at risk. Since chronic respiratory diseases increased 113%, it is obvious that a difference in hotel occupancy cannot explain the positive findings. Furthermore, the visits for heart diseases were actually fewer during the New Year's period.

Other confounding variables to consider include auto exhaust fumes, pesticides, pollens, and volcano emissions. It is not reasonable to suspect a pronounced change in the use of motor vehicles or pesticides. Two weeks should not greatly affect levels of biological allergens, and Kilauea did not erupt during this period.

The consumption of alcoholic beverages, however, must be considered as a confounding variable, and this possibility cannot easily be dismissed. Among adults, exposure to alcohol and fireworks pollution occurred together, and both hazards were essentially absent during the control period. We had hoped that a greater New Year's risk of respiratory illness among children would eliminate alcohol as a possible confounding factor, but such an association was not found. The best that can be said is that presently alcohol is not generally considered to precipitate asthmatic attacks frequently.

Finally, some of the negative findings of this study should be discussed briefly. The surprising observation that chronic respiratory disease (mainly asthma) occurred more often in children during the Christmas season deserves comment, even though the difference was not statistically significant. The Buffalo, New York study referred to earlier⁵ discovered an association between chronic exposure to moderate levels of particulate air pollution and asthma among children—not a single episode of pollution. Our findings agree with the other cited studies,^{1, 2, 3, 4} which report that adults with pre-existing asthma suffer mostly severely during pollution episodes.

It may be that some of our children with pre-existing asthma did feel worse on New Year's Eve, but that some other factor during the Christmas season affected the asthmatic children even more strongly. Since stress and anxiety are known to exacerbate asthma in some persons, the excitement of Christmas activity should be considered

as a possible cause. Study of a larger population might support or refute this suggestion. An earlier study of childhood asthma in Hawaii did report that attack rates were usually higher on weekends and short holidays, but unfortunately no figures were given.¹⁹

Since our observations were limited to illness severe enough to be treated in emergency rooms, we may not infer that our findings apply to the occurrence of all chronic respiratory disease, however mild. Our methods may thus be less than optimally sensitive in discovering associations between air pollution and illness. The examination of pollution in relation to mortality is likely to be even less sensitive, and this may account for the negative results of our death certificate analysis.

In conclusion it can be stated that the suffering of those afflicted by respiratory diseases is quite real during such a fireworks episode. On the other hand, the urge to uphold a cultural and religious heritage of a segment of Hawaii's population is also quite real. Perhaps the fact that the Greater Honolulu area is now one of the most densely populated areas in the world may have enhanced the adverse effects in recent years. We feel that with good will and a certain degree of consideration everybody's rights and well-being can be guaranteed. We recommend to display fireworks only along the Waikiki coastline and on the off-shore islands. Those, who want to, can participate, and others can enjoy the display from a distance without being harmed.

ACKNOWLEDGMENTS

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Sexing of *A. tristis*

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THIS PROBLEM, long a puzzle, can accurately be resolved by buccal smears, Barr body counts, 17-ketosteroids, pregnanetriol studies, adrenal suppression tests, serum electrolyte levels, chromosomal analyses and gonadal biopsies.³ Cloacal analyses are also productive of positive information. However, they are messy and many of us do not possess the alacrity to gather proper specimens for analysis.

The above are all invasive methods. While they produce positive information, there is also the matter of securing the individual's cooperation. THIS IS USUALLY UTTERLY IMPOSSIBLE TO OBTAIN.

By the use of eyeballing techniques, with practice, accurate determinations can be made. They usually travel in pairs so that direct comparison is possible. Eventually one can learn to tell them when seen alone.

The conformation of the male is definitely at variance with that of the female. The masculine pectoral muscles are larger and his shoulders are broader. He is generally somewhat larger than the female and walks with a more authoritative gait. The female tends to mince somewhat. He has definite protective habits as related to his companion and exhibits this in early adulthood. Biparietally the male's vertex is almost flat whereas the female's is slightly but noticeably convex. Sir Linnaeus has a small but definite occipital cap, which ereets when he is apprehensive or irritated. The chrome-colored harlequin periorbital skin extends further occipitally than on the female and tends to end in a slightly convex tip.

The females are comparatively "liberated," and distaff duties, such as the feeding of the young, are often performed by the male. His conduct toward his epithalamic partner is attentive and protective, and borders on the chivalrous. Since these traits are cognate, frequent and protracted observation is necessary.

Mr. Arthur Guinness has prepared a draught, which may be obtained from his place of business at St. James Gate, Dublin.⁴ It is available locally at the store of Maurice O'Suilleabain, of Honolulu.*

An intensive study of this supplemental preparation, conducted by Sean Paodraie O'Cianain,^{5†} awaits publication in the journal *Cumann Dochtuiri Faochy Oncology*⁵ *Ter Ni N'Og*.^{6‡}

One or two pints of this is of grand assistance to the observer, although after an overdose, inaccurate observations tend to creep in. During periods when there are no specimens to observe,

* Maurice O Sullivan, Foodland Super Market Ltd., 2919 Kapiolani Boulevard, Honolulu, Hawaii.

† Sean O'Cianain, Harkness Pavilion, Honolulu, Hawaii.

‡ *Medical Journal of Periwinkle Oncology* of the Ter Ni N'Og. The Ter Ni N'Og is the land of the enchanted people of all Ireland and is inhabited, so the story goes, by men and animals that were cast out of Heaven in an angry fit by God himself. The angel Gabriel pleaded with Him to stop before he emptied Heaven of all angels. God saw the point and immediately ceased casting the angels into Hell. Now, in transit between Heaven and Hell were thousands of souls of both humans and animals who, because of the suddenness of His change of mind, were left suspended for all eternity between Heaven and Hell. As a result there were thousands of cauns, leprechauns and cullichauns, all cobblers. The leprechauns make shoes for themselves and humans, the cullichauns make shoes for migratory birds. They were very tiny people who travel ahead of the birds to the shores of the Dead Sea. Of course, everyone knows that birds cannot fly over the Dead Sea—they would drop dead—so these little shoemakers provide them with tiny shoes which they put on and simply walk across the Dead Sea.



Illustration courtesy of Tom Fujisc, State of Hawaii, Department of Health.

*Scherenschnitte*⁷ should be indulged in, thus affording definite relief for the cunniseal ccebration that observers so often are afflicted with.

The conduct of these creatures is intelligent, at times somewhat aggressive, and always decisive.

Dr. Harry Arnold, Jr.⁸ published a now obscure paper decrying the fact that they have red and black mites. This is an important observation and should be borne in mind. (However, it was impolite of him to bring up the subject of mites.)

CONCLUSION

1. Mynah birds are different. With practice the male *can* be distinguished from the female.
2. Mynahs do no harm to other birds, keep down insect pests, rarely destroy fruit^{1, 2} and are extremely pleasant to watch while sipping Guinness' stout. They are no more quarrelsome than the average Irishwoman.
3. "All will be changed, changed utterly, a terrible beauty will be born."⁹

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*Speculations on relations of obesity, depot fats,
blood lipids and diminished fibrinolysis.*

Fibrinolytic Activity in Hawaiian and Japanese Men in Hawaii

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Determinations of blood fibrinolytic activity were performed on a number of Hawaiian and Japanese men living in Hawaii as part of a retrospective study of coronary heart disease (CHD). In general, fibrinolytic activity was greater in Japanese than in Hawaiians, the latter having a greater prevalence of CHD. In these subjects, fibrinolytic activity showed a significant positive correlation with obesity, blood pressure, and serum lipids and a negative correlation with age and the level of linoleic acid in depot fat. However, no clear cut evidence was found of a relationship of fibrinolytic activity to the presence of diabetes mellitus, or to previous history of smoking, or to CHD as determined by the presence of previous myocardial infarction.

THE HAWAII Cardiovascular Study¹ was initiated in 1962 as a retrospective investigation of coronary heart disease (CHD) in Hawaiian (Polynesian) and Japanese men in Hawaii. These two racial groups were chosen for study because previous reports demonstrated that Hawaiian men had the highest and Japanese men among the lowest CHD mortality rates in Hawaii.² A representative sampling of men from both racial groups who had suffered electrocardiographically-proven acute myocardial infarction were studied and compared with age-, race-, and sex-matched control subjects.

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In addition to the usual observations and measurements performed in epidemiologic studies of this nature, euglobulin lysis times and dilute whole-blood fibrinolysis times were also determined. The results of these studies form the basis for this report. Specifically, we have attempted to determine whether impaired fibrinolysis might play a role in the genesis of CHD by comparing fibrinolytic activity in groups with high and low risks for CHD and by studying the relationship of fibrinolytic activity to a number of known risk factors for CHD.

MATERIALS AND METHODS

Subjects. The selection of subjects for study has been described in detail in previous publications,^{1, 3} and only a brief outline will be given here. Studies were performed on 42 Hawaiian (Polynesian) and 68 Japanese men aged 37-69, living on the island of Oahu, Hawaii (cases). All had experienced electrocardiographically-proven acute myocardial infarction six months or more before the time of examination. In addition, similar studies were performed on 42 Hawaiian and 68 Japanese controls, matched for age, sex, and race, who had been hospitalized within 18 months of each's index case (hospital controls), and on a like number of similarly matched controls randomly chosen from the general population of Oahu (population controls). Each of the controls was free of detectable coronary heart disease.

Subjects were accepted as "Hawaiian" or "Japanese" if they were 25% or more of either race. Many of the Hawaiians were of mixed ancestry; with two exceptions, all Japanese were

of pure ancestry. Hawaiian-Japanese mixtures were excluded from the study.

Studies. All subjects reported as out-patients for study at approximately 7:30 a.m. following an overnight fast of at least 12 hours. Blood was obtained by venipuncture with minimal stasis, and the following studies were performed: serum cholesterol, serum triglycerides, plasma glucose, hematocrit, whole blood viscosity and clotting time.¹⁻⁴ Euglobulin lysis time (ELT) was determined by the method of Kowalski et al as modified by Gajewski.⁵ Determinations were done in duplicate, and lysis times were recorded to the nearest minute. Times of five hours or greater were recorded as "300 minutes." Dilute whole-blood fibrinolysis time (BLT) was determined by the method of Fearnley as modified by Lackner and Goosen.⁶ Determinations were done in triplicate, and lysis times were recorded to the nearest tenth of an hour. Times of 48 hours or greater were recorded as "48 hours." (Determination of euglobulin lysis time was performed on almost all subjects, but the determination of dilute whole-blood fibrinolysis time was added after the study was in progress; hence, it is not available on those examined earliest. This latter group is made up largely of primary cases, and, to a lesser extent, of hospital controls.)

A fasting urine specimen was analyzed for glucose by Testape.⁸ Height (without shoes) and weight (lightly clothed) were measured in the usual manner.

After the above studies had been completed, the subject was given a breakfast containing 85 grams of fat, with the further addition of one gram of fat per kilogram of body weight for those over 190 pounds. Blood was obtained by venipuncture at three hours after the breakfast (all population controls, and selected cases and hospital controls) for the determination of triglycerides, ELT, and BLT, and at six hours (all subjects) for the determination of triglycerides and BLT.

Following history-taking and physical examination, during which blood pressure was determined by a physician using methods previously reported,¹ a specimen of depot fat was aspirated from the right buttock,⁷ and depot fat fatty acid content was analyzed.⁸

Physical activity index was derived from information obtained from the medical history. The derivation of this index has been described in an earlier publication.¹

RESULTS

Case-Control Comparisons

Table 1 lists results of determination of fasting ELT on the Hawaiian and Japanese cases and controls. The mean fasting ELT for both the Hawaiian and Japanese cases was significantly greater than for the controls (245.8 vs. 225.6 minutes, $P < 0.05$ for the Hawaiians; and 235.5 vs. 211.0 minutes, $P < 0.005$ for the Japanese).

TABLE 1.—Fasting euglobulin lysis time—cases and controls.

			CASES	CONTROLS	T CASES VS CONTROLS	P
HAWAIIANS	Total	Number Mean S.E.	38 245.8 7.17	80 225.6 5.45	2.1426	<0.05
	Receiving Anticoagulant Therapy	Number Mean S.E.	13 262.9 15.46	2 294.5 5.50	0.7478	N.S.
	Not Receiving Anticoagulant Therapy	Number Mean S.E.	25 236.9 7.03	78 223.9 5.45	1.2397	N.S.
JAPANESE	Total	Number Mean S.E.	66 235.5 7.22	127 211.0 4.63	2.9475	<0.005
	Receiving Anticoagulant Therapy	Number Mean S.E.	27 264.0 8.47	0 0 0	0	.....
	Not Receiving Anticoagulant Therapy	Number Mean S.E.	39 215.8 9.58	127 211.0 4.63	0.4759	N.S.

However, as we have previously reported,⁹ the ELT of patients receiving coumarin-type anticoagulants was found to be prolonged. When the values of those subjects on anticoagulants were removed from the total group, there was no statistically significant difference in mean ELT between cases and controls in either the Hawaiian or the Japanese group. Fasting BLT was determined for only a small subsample of Hawaiian and Japanese cases. The mean BLT for 17 Hawaiian cases was 17.0 hours, while that for nine Japanese cases was 11.2 hours. These values are not statistically significantly different from those of their respective controls (Hawaiian 14.6 hours; Japanese 10.0 hours).

Interracial Comparisons

The difference in mean fasting ELT between Hawaiian and Japanese cases did not reach statistical significance in either the total group nor in the subjects not receiving anticoagulants ($t = 0.9308$, $P > 0.05$, and $t = 1.5749$, $P > 0.05$, respectively); however, in both instances the Hawaiian ELT was greater than that of the Japanese (Table 1). BLT was greater in the subsample of Hawaiian cases (17.0 hours) than in the Japanese cases (11.2 hours), but again, the difference was not statistically significant.

In Table 2 are listed the mean values for fasting and three-hour postprandial ELT in the Hawaiian and Japanese controls (none of whom were on anticoagulants). Both the fasting and

TABLE 2.—Euglobulin lysis time (minutes).

		FASTING	3 HOURS POST- PRANDIAL
HAWAIIANS (Normal controls)	Number	78	64
	Mean	223.9	184.7
	S.E.	5.45	5.53
JAPANESE (Normal controls)	Number	127	103
	Mean	211.0	174.6
	S.E.	4.63	5.16
t		1.7552	1.2770
P		N.S.	N.S.

three-hour postprandial values were more prolonged in the Hawaiians (223.9 and 184.7 minutes respectively) than in the Japanese (211.0 and 174.6 minutes respectively), but the difference did not reach statistical significance. However, the mean fasting BLT of the Hawaiian controls (14.6 hours) was significantly longer

($P < 0.05$) than that of the Japanese (10.0 hours) as shown in Table 3. The three- and six-

TABLE 3.—Dilute whole blood lysis time (hours).

		FASTING	3 HOURS POST- PRANDIAL	6 HOURS POST- PRANDIAL
HAWAIIANS (Normal controls)	Number	50	49	50
	Mean	14.6	7.6	6.9
	S.E.	1.76	1.26	0.93
JAPANESE (Normal controls)	Number	60	58	59
	Mean	10.0	5.8	5.8
	S.E.	1.14	0.43	0.49
t		2.193	1.383	1.038
P		<0.05	N.S.	N.S.

hour postprandial BLT values were also greater in the Hawaiians than in the Japanese, although these differences did not reach statistical significance.

Examination of Specific Factors
Related to Fibrinolytic Activity

The effect of diurnal variation on the postprandial fibrinolysis in both groups was striking (Tables 2 and 3). In all instances, the three- and six-hour postprandial euglobulin lysis and dilute whole blood fibrinolysis times were shortened, despite the fact that all subjects had previously consumed a high fat breakfast, producing a significant rise in serum triglycerides.*

In order to further study this phenomenon, 13 subjects subsequently returned and ingested an isocaloric low-fat breakfast after fasting blood studies had been done. In these subjects, there was an average rise in triglycerides three hours postprandially of only 20 mg.%, as compared with a mean rise of 146 mg.% in the same subjects after a high fat breakfast. Following the high fat breakfast there was a mean decrease in BLT of 7.9 hours and in ELT of 36 minutes when determined three hours after the meal, while similar determinations following the low fat breakfast revealed decreases of 5.5 hours in BLT and 23 minutes in ELT. Hence we were unable to demonstrate any significant inhibition of fibrinolysis by a high fat breakfast as measured by ELT or BLT.

Correlations between BLT and serum lipid concentrations are given in Table 4. Among the Japanese controls there was a statistically significant positive correlation between BLT and both

* Mean value at six hours more than twice fasting value.

TABLE 4.—*Relationship between fibrinolysis (BLT) and various lipids.*

		DEPOT FAT FATTY ACID						
		CHOLESTEROL	TRIGLYCERIDE	16:0	16:1	18:0	18:1	18:2
HAWAIIANS (Normal controls)	N	50	50	50	50	50	50	50
	r	0.153	0.234	0.200	0.273	-0.236	-0.120	-0.191
	P	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
JAPANESE (Normal controls)	N	60	60	60	60	60	60	60
	r	0.336	0.352	0.075	-0.072	0.112	0.012	-0.005
	P	<0.01	<0.01	N.S.	N.S.	N.S.	N.S.	N.S.
COMBINED HAWAIIANS AND JAPANESE	N	110	110	110	110	110	110	110
	r	0.232	0.264	0.172	0.138	-0.086	0.036	-0.191
	P	<0.05	<0.01	N.S.	N.S.	N.S.	N.S.	<0.05

serum cholesterol ($r = 0.336$; $P < 0.01$) and serum fasting triglyceride levels ($r = 0.352$; $P < 0.01$). Although there was a slight positive correlation between BLT and both cholesterol and triglycerides in the Hawaiian controls, in neither case did it reach statistical significance. When the Hawaiian and Japanese controls were combined for analysis, the statistically significant correlations between BLT and cholesterol ($r = 0.232$; $P < 0.05$) and triglycerides ($r = 0.264$; $P < 0.01$) were again noted.

There were no statistically significant correlations between BLT and any of the levels of the various fatty acids determined from depot fat aspiration samples in either the Hawaiian or the Japanese controls. However, a negative correlation which was significant at the 5% level ($r = -0.191$; $P < 0.05$) was noted when the fibrinolysis times of the combined Hawaiian and Japanese control groups were compared with the levels of linoleic acid (fatty acid 18:2) in their depot fat samples.

trol groups, but this did not reach statistical significance until both groups were combined ($r = -0.253$; $P < 0.01$).

A markedly positive correlation between weight (as well as weight/height, an estimate of overweight) and BLT was noted in both the Hawaiian and Japanese controls separately and combined ($P < 0.01$ in all instances).

There was a slight, but not statistically significant positive correlation between systolic blood pressure and BLT in both the Hawaiian and Japanese controls; the correlation coefficient did reach statistical significance ($r = 0.194$; $P < 0.05$) when the two groups were combined. However, a statistically significant correlation was noted between diastolic blood pressure and BLT in the Hawaiian and Japanese control groups separately ($r = 0.334$; $P < 0.05$ and $r = 0.396$; $P < 0.01$, respectively), as well as in combination ($r = 0.395$; $P < 0.01$).

There was no statistically significant correlation between BLT and physical activity index as

TABLE 5.—*Relationship between fibrinolysis (BLT) and selected physical variables.*

		AGE	WEIGHT	WEIGHT/ HEIGHT	SYSTOLIC BLOOD PRESSURE	DIASTOLIC BLOOD PRESSURE	PHYSICAL ACTIVITY
HAWAIIANS (Normal controls)	N	50	50	50	50	50	50
	r	-0.253	0.539	0.574	0.103	0.334	0.071
	P	N.S.	<0.01	<0.01	N.S.	<0.05	N.S.
JAPANESE (Normal controls)	N	60	60	60	60	60	60
	r	-0.190	0.316	0.358	0.245	0.396	0.059
	P	N.S.	<0.01	<0.01	N.S.	<0.01	N.S.
COMBINED HAWAIIANS AND JAPANESE	N	110	110	110	110	110	110
	r	-0.253	0.491	0.521	0.194	0.395	0.094
	P	<0.01	<0.01	<0.01	<0.05	<0.01	N.S.

Table 5 reveals correlation coefficients for the comparison of BLT with age, weight, weight/height, blood pressure and physical activity index. A negative correlation between BLT and age was noted in both the Hawaiian and Japanese con-

determined by medical history. No attempt was made to correlate BLT with physical activity immediately prior to determination of fasting BLT, but in all cases subjects reported for study at approximately 7:00 a.m., shortly after arising.

No correlation was noted between BLT and hematocrit, Lee-White clotting time, or whole blood viscosity.

controls) and their mean BLT was 27.3 hours as opposed to a mean BLT of 13.0 hours for the two whose weight/height ratio was less than 2.65.

TABLE 6.—*Relationship of smoking to fibrinolysis.*

		HAWAIIANS (Controls)		JAPANESE (Controls)	
		ELT (min.)	BLT (hr.)	ELT (min.)	BLT (hr.)
SMOKERS	N	58	41	93	39
	Mean	221.0	14.1	213.2	9.7
	S.E.	6.35	1.94	5.36	1.46
NON-SMOKERS	N	20	9	34	21
	Mean	232.2	17.0	205.2	10.6
	S.E.	10.66	4.27	9.21	1.82
	t	0.8783	0.6225	0.7575	0.3451
	P	N.S.	N.S.	N.S.	N.S.

Table 6 reveals that there was no significant difference in ELT or BLT in either the Hawaiian or the Japanese controls, when comparing smokers with non-smokers. In general, lysis times were a bit shorter in smokers (except for ELT in the Japanese), but none of these differences reached statistical significance.

Hence, from these data it is impossible to state that diabetes mellitus (in the absence of obesity) leads to a prolongation of BLT in the Hawaiians.

DISCUSSION

The recent demonstration of the breakdown

TABLE 7.—*Relationship of diabetes mellitus to fibrinolysis.*

		HAWAIIANS (Controls)		JAPANESE (Controls)	
		ELT (min.)	BLT (hr.)	ELT (min.)	BLT (hr.)
DIABETICS	N	11	7	14	9
	Mean	237.2	23.2	224.0	8.3
	S.E.	12.80	5.46	13.93	1.90
NON-DIABETICS	N	67	43	113	51
	Mean	221.7	13.2	209.4	10.3
	S.E.	5.98	1.78	4.91	1.29
	t	0.9773	1.9921	0.9784	0.6274
	P	N.S.	<0.05	N.S.	N.S.

Table 7 examines fibrinolysis in diabetic and non-diabetic Hawaiian and Japanese controls. For the purposes of this analysis, a diabetic subject was defined as one who gave a positive history of diabetes mellitus and/or had a fasting blood glucose of 120 mg% or higher. Among the Japanese there was no statistically significant difference between diabetics and non-diabetics as measured either by ELT (224.0 vs. 209.4 min.) or by BLT (8.3 vs. 10.3 hours). Nor did the difference reach statistical significance among the Hawaiians when measured by ELT (237.2 min. for diabetics vs. 221.7 min. for non-diabetics). However, the BLT was statistically significantly longer among Hawaiian diabetics than among the non-diabetics (23.2 vs. 13.2 hours; $P < 0.05$). Five of the seven Hawaiian diabetics were overweight (as determined by a weight/height ratio of greater than 2.65, the mean value for Hawaiian

products of fibrin in the serum of normal persons^{10, 11} lends support to the hypothesis that there is a dynamic equilibrium between coagulation and fibrinolysis in the normal circulation. If such is the case, factors which inhibit fibrinolysis could upset the equilibrium and lead to pathological coagulation which might be important in the genesis of coronary heart disease (CHD). A number of previous studies have examined the relationships of certain variables to fibrinolysis in man. Among the factors which have been shown to affect fibrinolytic activity are exercise, obesity, venous stasis, time of day (diurnal variation) and certain drugs. Many other factors have been suggested to have a relationship with fibrinolysis, but with less convincing evidence. Among these variables are age, sex, race, blood lipids, diabetes mellitus, smoking, anticoagulants, arteriosclerosis, and beer drinking.¹²

The Hawaii Cardiovascular Study has provided an opportunity to study in detail these and other variables in two separate male populations with markedly different prevalences of mortality rates due to CHD. Native Hawaiians (Polynesians) have been shown to have much more CHD than a similar group of Japanese men living in the same geographical area (Oahu, Hawaii).^{2, 13} In a previous report¹ it has been suggested that the high CHD rate in Hawaiian men could be most closely related to the fact that they tend to be overweight, have a high prevalence of carbohydrate intolerance, and suffer from hypertension.

In the present study we have shown that fibrinolysis was consistently more active (ie, fibrinolysis times were shorter) in Japanese cases and controls than in their Hawaiian counterparts, whether measured by euglobulin lysis time (ELT) or dilute whole blood fibrinolysis time (BLT). The difference was most clearly demonstrated in the controls by BLT. This is consistent with the fact that Hawaiians have a higher prevalence of coronary heart disease than the Japanese. However, if defective fibrinolysis is causally related to the development of CHD, one would expect that fibrinolysis would be more defective in patients with CHD than in those without evidence of such disease. This was not the case. Indeed, there was no significant difference between the BLT's of either Hawaiian cases and controls or of Japanese cases and controls. The same was true for ELT determinations when one takes into account and corrects for the fact that coumarin anticoagulants can cause a prolongation of ELT.⁹ There was no significant difference in ELT between cases not on anticoagulants and controls in either racial group. This suggests that the prolonged fibrinolysis in Hawaiians as compared with Japanese is a secondary phenomenon and may not directly causally relate to their development of CHD.

The relationship of blood lipids to fibrinolytic activity has been the source of much comment and controversy.¹⁴ A number of reports^{5, 15, 16, 17} suggest that ingestion of fat inhibits fibrinolysis, but this has not been convincingly substantiated.^{18, 19} Likewise, reports suggesting a correlation between fibrinolytic activity and cholesterol or triglyceride levels^{20, 21} are countered by those finding no such relationship.^{18, 22, 23} To our knowledge no one to date has attempted to correlate fibrinolytic activity with the fatty acid pattern of depot fat.

Our studies suggest a relationship between fibrinolysis and the levels of serum cholesterol and triglycerides, especially among the Japanese.

Increasing levels of either lipid fraction were associated with diminishing fibrinolytic activity (prolonged fibrinolysis times). In spite of this, the acute ingestion of a high fat meal, sufficient to produce a significant rise in serum triglycerides, had no discernible inhibitory effect on fibrinolysis; indeed, fibrinolysis time was shortened in almost all patients after such a meal, an occurrence which is probably related to physical activity or diurnal variation or both.²⁴ This suggests that the chylomicron (the form in which lipids appear in the blood after the acute ingestion of fat) has little direct effect on fibrinolysis. Alternatively, of course, our methodology may be too insensitive to measure minimal inhibition of fibrinolysis caused by chylomicrons. This is especially likely to be true for the ELT determination in which many of the inhibitors of fibrinolysis are removed during precipitation of the euglobulin fraction.¹² In determination of the BLT, however, inhibitors are diluted but not removed from the system.

On the other hand, the relationship between fasting serum cholesterol and triglyceride levels suggests that these levels might directly affect fibrinolysis or that other factors exist which affect both serum lipid levels and fibrinolysis.

Interestingly, there was no correlation of fibrinolytic activity with the level of any of the depot fat fatty acids except for linoleic acid, which was negatively related to fibrinolysis time (greater fibrinolytic activity was seen in those subjects with highest levels of linoleic acid). This relationship was present in Hawaiian controls, but it reached statistical significance only when the number of subjects was increased by analyzing Hawaiian and Japanese controls together. Linoleic acid, unlike most of the other major components of depot fat, is an essential fatty acid²⁵ and is obtained only by dietary intake (ie, endogenous synthesis does not occur). Therefore, levels of this fatty acid are high in those patients whose diets are high in polyunsaturated fatty acids. Whether dietary polyunsaturated fatty acids actually stimulate fibrinolytic activity as has been proposed by Gajewski and others,^{5, 26} or whether the increased activity associated with high depot fat linoleic acid (or vice versa) is related to other factors which tend to produce both elevated depot fat linoleic acid and increased fibrinolysis (or whether the relationship is merely fortuitous) cannot be answered on the basis of this study. However, further studies of this phenomenon would seem to be in order, especially in view of the recent interest in the use of diets high in unsaturated fatty acids to prevent CHD.²⁷

An inverse relationship between age and BLT was noted in this study. Such a relationship has been previously described, and Chakrabarti has suggested that it is related to the possible occurrence of a higher mortality rate among persons with deficient fibrinolysis.²⁸

A history of cigarette smoking was not significantly related to fibrinolytic activity, an observation in contrast to reports suggesting that such a relationship does exist.²⁹

We were unable to discover any direct effect of diabetes mellitus on fibrinolytic activity when the factor of obesity was taken into account; but, admittedly, our sample was small. Failure to consider the contribution of obesity may be the reason for some of the reports suggesting that diabetics have impaired fibrinolysis.^{12, 30}

The relationship of blood pressure to fibrinolysis which was noted here is interesting. Hypertension is a risk factor for CHD;³¹ and since in our study hypertension was associated with diminished fibrinolytic activity in both population groups, this observation is again consistent with a role for defective fibrinolysis in the genesis of CHD. An alternative explanation, however, is suggested by the fact that, in general, hypertension and obesity are correlated;³² hence, the diminished fibrinolytic activity associated with hypertension may simply be due to the obesity factor in hypertensives.

The effect of obesity on fibrinolysis has been demonstrated in many reports.^{33, 34, 35} Our results confirm the fact that there is a strong inverse correlation between obesity and fibrinolytic activity, a relationship that was true in both the Hawaiians who have a high prevalence of overweight and the Japanese who do not. This correlation is so impressive, in fact, that as noted above, many

other seeming relationships may be mediated through the common denominator of obesity.

This study, therefore, points up the difficulty in assigning a contributory role to defective fibrinolysis in the genesis of CHD. On the surface, many of our observations would suggest that impairment of fibrinolytic activity is related to CHD. For instance, Hawaiian males have a higher prevalence of CHD and have less active fibrinolysis than Japanese males. In addition, we have found a definite statistical correlation among fibrinolytic activity and a number of known risk factors for CHD such as obesity, blood pressure and serum lipids.

The relationship to obesity is so strong that all the other correlations with fibrinolytic activity may be due only to their relationship, in turn, to obesity. In persons with obesity, diminished fibrinolysis may well contribute to the subsequent development of CHD. However, on the basis of this study, we are unable to assign to defective fibrinolysis a definitive role in the etiology of CHD.

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Resolution

WHEREAS, many delegations might think that California is already well stocked with nuts, and

WHEREAS, the Hawaii Delegation obviously does not subscribe to this patently absurd hypothesis, as evidenced by its recent generous contribution to our snacking enjoyment; therefore, be it

Resolved, that the California Delegation officially thank the Hawaii Delegation for its generous gift of several cases of macadamia nuts which we hope all present will help us enjoy.

Presented by the California Delegation on this 28th day of November, 1972 at the AMA Convention in Cincinnati, Ohio.

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Poinsettia: Probably Not Poisonous!

The milky juice or latex of plants of the spurge (Euphorbiaceae) family has long been believed to be poisonous, and that of some species of the genus *Euphorbia* probably is.

The long-rumored poisonousness of poinsettia (*Euphorbia pulcherrima*) seemed to be affirmed by Arnold's report that a 2-year-old child at Fort Shafter died in 1919 after eating a poinsettia leaf.¹ Arnold has since stated, however, that this report was only hearsay.²

In Mexico, on the contrary, the leaves have long been used as poultices for skin lesions, and brewed and drunk by nursing mothers to improve lactation.³

Stone and Collins at Ohio State University have recently studied the toxicity of leaves, flowers, and red bracts of the poinsettia, by force feeding groups of rats with the pureed material in very large

amounts. Not a single rat showed any ill effects whatever.⁴ The results coincided very well with chemical studies previously made which showed that the poinsettias contain only common sterols and triterpenes, none of which are ordinarily toxic.

On the whole, it seems highly probable, indeed, very nearly certain, that the poinsettia is not poisonous to man; certainly it can be handled with perfect safety, and very probably it could be eaten, even in large amounts, without ill effects.

H.L.A.

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Vitamin C Requirement in Man

The promotion of large doses of vitamin C for the prevention of colds, by Linus Pauling, was received with skepticism and some amusement by most physicians, especially after Dr. Pauling's well-publicized cold. The laughter died down considerably when Charleston and Klegg published their finding of a 49% lessened incidence of colds in 47 subjects given 1000 mg of vitamin C daily for 15 weeks—as compared to 43 controls taking a placebo.

Maybe the laughter ought to die away altogether for a while, until we can look into the matter seriously. Our standard for the minimum daily requirement of vitamin C has been simply the amount needed for the prevention of the most serious and obvious effect of total deprivation of vitamin C: *scurvy*. There is other evidence on which such a standard might be based.

One piece of such evidence, advanced by Dr. Pauling, is the amount of vitamin C naturally ingested by the gorilla, who, like man, has to ingest this substance preformed, being unable to manu-

facture it. He gets, in his large vegetable diet, nearly 5 grams of ascorbic acid a day. If man ingested as much, in proportion to his weight, he'd get about 2 grams a day instead of 50 to 100 milligrams.

Another datum is the amount of vitamin C manufactured internally by the many animals who make their own. It reaches the astounding amount of 2 to 15 grams per day, per 70 kilograms of animal! There is no reason to suppose that man's need for ascorbic acid is less, for any cause, than that of these other animals. There is every reason to suppose that we need the same amount for our tissues, weight for weight, as guinea pigs or gorillas need for theirs.

If so, we're shortchanging ourselves severely, and we *might* be a lot better off if we raised our sights to the daily intake of vitamin C we'd be getting if we got all our food from vegetables. It would be, intriguingly, about 2 grams a day! Think it over.

H.L.A.



The President's Page

H.R. 1, now known as P.L. 92-603, was signed by President Nixon on October 30, 1972. This 989-page law includes the provision (Sec. 249F) for Professional Standards Review Organizations. The stated purpose of the law is to secure effective, efficient and economical delivery of health care services for which payments can be made under the Social Security Act. It is important that all physicians become familiar with P.L. 92-603. A copy will be placed in the Medical Library.

State and county medical societies cannot function directly as PSRO's, but can create other organizations which can function in this capacity.

The Hawaii Foundation for Medical Care is such an organization and with its recent transfer from the Honolulu County Medical Society to the Hawaii Medical Association is in a favorable position to become a PSRO. In fact, a letter of intent has already been filed with HEW.

EMCRO was designed as an educational tool for the physicians. This is still the prime purpose of EMCRO. The techniques developed can be used by the PSRO in the review process. By using the EMCRO methodology we have a start on PSRO activity and can go ahead with a minimum of disruption. P.L. 92-603, although unpalatable to many of us, is now law.

Guidelines and regulations for PSRO's will be released early in 1973. We are preparing to submit our proposal for the Foundation to become a PSRO.

We plan to incorporate the knowledge gained under EMCRO into the program and develop our PSRO so that it will be acceptable to the practicing physician and will give recognition to patient problems. Peer Review is not new to us. Critical self evaluation is an important professional component.

Better care for our patients and the conservation of the health care dollar should be our objective.

William F. Iaconetti M.D.

AMA News in Brief



AMA's 1972 Opinion Survey revealed that AMA members and non-members pretty well agree on major issues. Both members (73.2%) and non-members (66.9%) want AMA to continue to seek to retain basic principles of private practice in any government health program that might be enacted. Comparable proportions of members (24.6%) and non-members (27.5%) said they would practice under a nationalized health program if it were enacted.

Physicians run the risk of being subjected to retroactive denial of Medicare benefits unless they are able to provide acceptable documentary evidence sustaining dates of their hospital visits, the AMA warns. As a precautionary measure, the AMA urges physicians to "make sure that there is an entry on the hospital record for each patient substantiating the date of each visit." To guide physicians the AMA has developed an informational statement based on Medicare rules and verified by the Bureau of Health Insurance. Write the Division of Medical Practice, AMA.

Special phone service for physicians seeking information or guidance on Phase 2 price controls is provided by the AMA. Just call (312) 527-1571, Ext. 434, and ask for Robert Walsh of the AMA Center for Health Services Research and Development. After closing hours messages will be recorded so that callback answers can be made. The AMA has received about 25 calls a week since establishing the service in August.

Overwhelming MD response has greeted a financially attractive new insurance program sponsored by the AMA as an added benefit of membership. Nearly 20,000 dues-paying AMA members enrolled in the \$250,000 Excess Major Medical Insurance program during the initial two-month enrollment period.

To help physicians establish themselves in practice the AMA is developing a series of seminars emphasizing basic management techniques. Residents who participate in the 2½-day workshops will receive guidance on practice planning and management and on legal aspects of medicine. There is a \$25 registration fee for those who are not AMA members. Direct inquiries to Department of Practice Management, AMA.

Emergency loan program jointly established by the Pennsylvania Medical Society and the AMA helped nearly 150 flood-stricken physicians re-establish their practices. PMS and AMA allocated \$300,000 each to provide interest-free loans of up to \$5,000 to physicians whose offices were damaged by Hurricane Agnes.

AMA Trustees visited 42 of the 1972 annual sessions held by state medical societies. Purpose of the special State Visitation Project, launched last spring by the Board of Trustees, was to improve communications between the AMA, state medical society officials and individual physicians. Through face-to-face discussions, Board members gained a better understanding of problems that are of primary concern to individual physicians and obtained suggestions on how to attack these problems. They also described AMA programs and activities.

Significant progress in devising a standard form for claims reporting has been reported by an AMA-sponsored work group representing 10 national organizations and federal agencies. It has reached agreement on the form's content and is now designing a form that will be computer-adaptable.

The AMA is sponsoring a series of 10 regional seminars for medical directors and administrators of long-term care facilities. The two-day programs stress managerial techniques that will lead to better patient care. The seminars are financed by a \$172,000 grant from HEW. For details contact Department of Hospitals and Health Facilities, AMA.

New AMA publications for MDs: *Human Sexuality*, a 300-page guide on sex counseling \$5.95. Write Order Department, AMA. *Health Care Delivery in Rural Areas*, 48 pages, no charge. Write Department of Rural Health, AMA.

The AMA is assisting 23 medical specialty associations in efforts to develop guidelines for use in local peer review activities. Participating in the program are representatives from those specialty associations that comprise AMA's Interspecialty Council. The guidelines will be developed independently by the individual specialties with the AMA serving in a coordinating role.

HMA Outreach

HAWAII MEDICAL JOURNAL

MEDICAL SERVICES

The **Workmen's Compensation Committee** has worked long and effectively in considering support of proposed legislation accepting the 1970 RVS with a conversion factor(s) that can be varied from year to year based on the fluctuation of the CPI.

In an effort to aid the Department of Labor, a subcommittee composed of Drs. Chun-Hoon, Liechter, Luke, and Shepard have also drafted a well thought-out plan to present to the Council for *rehabilitation* of Workmen's Compensation patients. Hopefully, undue delays in the rehabilitation of these patients will be avoided so that fewer patients will be caught up in a web of socio-economic dependency.

HOUSE OF DELEGATES

The House of Delegates at its recent Constitutional Convention made many changes in the BY-LAWS reflecting recommendations made by the HMA Blue Ribbon (five past presidents) Committee reviewing the reorganization of the HMA. Included were: (1) changes in committee structure; (2) inclusion of the county presidents as members of the Council as well as one councillor per 100 members (which increases the number of HCMS councillors to six); (3) a seat for one each of SAMA and HAIR representatives in the House of Delegates; (4) direction to the Council to develop a manual of Procedures, Rules, and Regulations for the HMA and a job-description manual; (5) acceptance of the Foundation by the House of Delegates; (6) direction to the Council to come up with: (a) a recommendation on a means to meet the future *Housing Needs* of the HMA, and (b) to explore and report other Blue Ribbon Committee recommendations, ie, establishment of the legislative "Key Man System," and various budget considerations.

ACTIVITIES

The **Cancer Committee** (T. Lau) received a report that the contract for funding of the Tumor Registry was prepared and signed. With periodic renewals, it should carry through 1974.

Communicable Disease Committee (L. T. Chun) is in accord with a program to catch up with tetanus and diphtheria immunizations on

Kauai being planned by the Department of Health for early 1973. The committee has also urged the Department of Health to hire a full-time VD control officer and noted that the School Health and Crippled Children Committees have been established as two separate committees of HMA.

TV Committee (T. Tseu) is planning HOT-LINE for 1973 and is investigating means of continued community sponsorship for this program for which the HMA will furnish topics of interest and panelists gratis.

Thanks to Bill Goebert, the Woman's Auxiliary and the HMA staff, *Careers Day* was a great success again this year and more young doctors expressed interest in working with the next effort.

The **Health Facilities Committee** (W. Chang) is continuing its study of ECF's and ICF's, their proposed functions and needs.

The first joint *HMA* and *Hawaii Newspaper Agency* FORUM on Obesity was "sold out" weeks in advance, with great public interest expressed. The next forums are planned for January, March, and May.

The **Public Affairs Committee** (R. Liechter) stays busy with various problems including MD's names being used without their permission by persons promoting their own activities.

Manpower Committee (H. H. Chun) is recommending that the state due to expenses involved and a 300% increase in licenses issued this year in Hawaii, not develop special educational programs to retrain foreign medical graduates who cannot pass their ECFMG's as there does not seem to be a critical shortage of physicians here and these people seem to represent countries in which such shortages do exist. It suggests that persons so involved be referred to programs already developed in mainland centers which are geared to meet their needs.

The **University of Hawaii School of Medicine** has already been awarded a one year contract by the Office of Special Programs, Bureau of Health Manpower Education, NIH, for training assistant to primary care physicians along with twenty-four other schools. All twenty-five PA programs must meet the "Essentials of an Approved Education Program for the Assistant to the Primary Care Physician" issued by the AMA's Council on Medical Education, according to MEDIHC.

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Slants and Angles

HAWAII MEDICAL JOURNAL

The Challenges of Change*

The central theme of this conference is the optimal delivery of health care and education to the people of our country at a time of rapid social change. Specific health problems and the particular role of the voluntary health agencies will be discussed here in detail over the next three days. However, all health care programs have profound social, political, and economic importance which is presently being reemphasized by the current demands for greater individual rights and freedoms, prominent among which is the right to good health. Therefore, in order to assess the potential impact of these health care programs on our future way of life, we must first obtain a broad over-view of the current social scene at this critical juncture in the history of our nation.

The winds of change are blowing strongly through all segments of our society and there can be no doubt that we are in the throes of a social upheaval of unparalleled proportions which is now reshaping Western civilization. These profound changes affect each and all of us in some way; by changes in our standards of behavior, in our individual freedoms, in our acceptance of authority, and in our interpersonal relationships. The rate of change of these events, attitudes, and standards is taking place much more rapidly than at any other time in history. We are all speeding along a steep, accelerating curve of change without being able to see what lies around the corner.

OUR TECHNOLOGICAL ERA

Our era is one of technological miracles; of instant communication and alienation, of increasing leisure and boredom, of banking by computer and then trying to argue with the damned thing when it makes a mistake. Yet, despite all these scientific "wonders," a deep sense of uneasiness and discontent pervades our society. There seems to be a widely held and deeply felt conviction that something is seriously and fundamentally wrong with our present life style.

In the summer of 1971, a jury of American humanists heard adversary arguments and then declared the uses and applications of technology "a clutch of tools and techniques that gave us the

aerosol can, the disposable baby bottle, better health, leisure, human data banks, opinion polls, moon walks, antipersonnel bombs, the split-level nucleus, and other things"; guilty of having, on balance, lowered the quality of human life.

COMPUTERS AND CONSCIENCE

Consider for a moment the digital computer. This has now become the supreme symbol, the ruling deity of our technological era. To the uninitiated, an aura of mystery, even of magic, surrounds it. Seemingly inexhaustible, it can perform any task from calculating complex mathematical formulas to choosing one's future wife; all with lightning speed, and ruthless efficiency, and of course without any possibility of error. Disciples of the new technology talk glibly of computer intelligence and some would even ascribe to them such human qualities as humor and emotion.

Yet, after all is said and done, a computer is just a machine which can store and retrieve information and make decisions based on this information. However, being a machine, it is concerned only with facts. Not even all the facts in a given situation, but only those that it has been programmed to utilize. Herein lies the computer's fatal flaw, its Achilles heel. Dealing only with facts, it has no need of philosophy and knows no aesthetic values. Its decisions are singly free of such troublesome distractions as morality, ethics, and humanity.

A computer can, after a fashion, describe a man and a woman; their height, weight, blood count, and biochemical composition. However, it will not, because it cannot, tell you that this man and this woman love one another, although this is to them the single most important thing in their lives. A computer may accurately evaluate a famous painting, its size, the different colors, patterns, and shapes, even the chemical composition of the canvas and pigments. Yet, it cannot convey the artist's vision of man's struggle with destiny which makes this painting a work of genius.

Another serious problem with computers has been described by E. E. Morison: "... looms, engines, generators—resisted at critical points human ignorance and stupidity. Overloaded, abused, they stopped work, broke down, blew up and that was the end of it. Thus, they set clear

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* Keynote address delivered September 26, 1972, at the Western Tuberculosis Conference, Honolulu, Hawaii.

Hawaii Academy of Family Physicians



. . . TEN YEARS AGO TODAY

The November-December issue of the HAWAII MEDICAL JOURNAL in 1962—exactly ten years ago—came out with the first of these guest editorials, one page six times a year. Your “guest” may have become a permanent fixture in the house of HMJ, and may claim tenure by right of eminent domain perhaps.

It is interesting to note that that first editorial, under the banner of the predecessor Hawaii Academy of General Practice, is as pertinent today as it was then. Some things in medicine never change! The 1962 editorial is reprinted below.

J. I. FREDERICK REPPUN, M.D.

20 October 1972

Although the general practitioner of medicine has not aimed at formal certification as such, in an age of certified medical specialists, he has formed an association with those of his colleagues who aim to raise the standards within the field.

This association is unique in that it specifies only the basic requirements for initial membership—those of graduation from an accredited medical school, licensure, membership in county and state medical societies, one year of internship plus two-to-three years of further training or experience.

APPROVED STUDY REQUIRED

The association goes on to require a specified number of hours of approved postgraduate study each three years, or membership will be forfeited. No medical specialty has this requirement.

The American Academy of General Practice aims at building in an incentive to keep physicians from sliding gently but inevitably down the groove to stagnation.

Statistics have indicated the growth of specialization during the past 30 years. The factors involved in this trend are undoubtedly multiple. A major one is the infinitely greater amount of medical knowledge in the books today. The medical graduate of 30 years ago hung up his shingle with a humble realization that he knew very little about anything; but then, neither did a specialist!

Today's graduate may also step out of medical school, appalled at the prospect of coping with his first patient, but for a different reason. It is natural

to expect, therefore, that he will soon narrow his interests and attempt to gain mastery of a specialty.

FIGHTING THE TREND

The generalist of yesteryear needed only intestinal fortitude to bolster his sense of his own ignorance. Today, the man who dares consider the prospect should be congratulated for superior courage.

What, then, might be the prospect facing such a neophyte with the courage required? Perhaps he sees a vista before him, an ever widening path of experience in human relations, of medical counseling and medical management. He sees patients on all sides, eager and anxious to have a family medical friend. He is able to help and advise with the wisdom he derives from the modern wealth of literature that has smoothed the path of error before his tread. He should also realize that he will be able to call on a team for assistance. Thus the burden of responsibility, that rested so heavily on the solo country doctor of the older generation, is something that the younger man can now share.

The path is, however, beset with man-made discouragements too. Primarily as a result of economic pressures, many of the specialties have shut doors in the face of the generalist. He faces the discouraging prospect of not being allowed to enter into the workshop of medicine—the hospital.

IS IT FAIR?

Under the somewhat spurious guise of maintaining high standards, and the pious sentiment that “guild members” can do no wrong, many of the specialties are attempting to restrain the younger man eager to gain a partial knowledge and experience. It is understandable that much of this is in reaction to the unscrupulous and ambitious practitioner who spoils it for the rest. However, men have a tendency to shy away from direct confrontation of a nasty issue by passing new and sweeping restrictive rules and regulations in an unfair manner.

The AAGP is a growing, vigorous association whose very growth in size and stature (second only to the AMA in number of members) is a mute denial of the cliché that the GP is becoming extinct.

The organization recognizes the forces of medical economies currently in effect. It is trying hon-

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ICHD Reports



ECG SCREENING

Your Hawaii Heart Association spends the donation dollar in a number of different ways to help those in Hawaii suffering from heart disease. Besides public education, local research, cardiopulmonary resuscitation training programs, subsidizing rheumatic fever prophylaxis, administrative needs, and other projects, the HHA provides two highly visible community services. One of these is the ECG screening device for adults and the other is the heart sound screening device for fourth-grade school children. Some information about the former will be conveyed in this editorial and an overview on the latter in a subsequent report.

The ElectroCardioAnalyser (ECA) is a small relatively inexpensive (\$10,000) computer that compares the input of five ECG leads with normals for adults. The results of this comparison are designated by lights on the front of the machine. A number of alternatives are possible. It may indicate the "R" wave if lead V5 is higher than normal; the baseline is unstable; 60-cycle artifact makes the signal uninterpretable; etc. Basically, the results fall into three categories; Within Normal Limits, Outside Normal Limits, or Technically Unsatisfactory. It does not provide the usual interpretation; not because "consistent with" cannot be translated into computer language, but because it would require a much more sophisticated (and expensive) computer than we carry around.

Dubious about the manufacturer's claim from one study that had been done using this machine, Dr. A. Morris, Dr. J. Orbison and I screened 1,000 successive employees at Queen's Medical Center and compared the screening with a 12-lead ECG performed immediately afterward.¹ We found there were 25% false negatives for what we chose to call significant ECG abnormality, as opposed to the Company's claim of 2.7%.² In persons over 40, false positives outnumbered true positives over 2:1, and all true positives about 4:1. Another way of expressing it would be that the machine can pick up 75% of those over 40 years old with a significantly abnormal resting ECG at the "expense" of calling twice as many abnormal as there really are.

It was decided the device would be useful as a screening mechanism to the community on request. The way the operation has evolved, a community group, usually the Lions Club, promises to have more than a hundred people available to be screened, and to provide a suitable place with electrical outlets, preferably with adequate grounding. The requests are placed with the local HHA chapters, who provide the essential volunteers to perform the screening. Jerry Conover of the HHA then schedules with the local volunteer a time he will travel to their island with the ECA machine, small mattresses for the patients to lie on, physical screens, the necessary electrical connections, and various paper supplies. The actual screenings may take half a day or two days.

In the four years of operation, 28,320 individuals have been screened. In the immediate past year, there were 11,365 screened, including 26 neighbor island communities amounting to a total of 57 days screening on the neighbor islands out of a potential 270 days. No screening is scheduled during the summer, because of the poor response.

The results of the screening are mailed to the private physician designated by the person screened. There is a feedback form attached to the ONL reports. Surprisingly, the number returned is about 60%. Approximately half of these indicate an abnormal ECG or other significant diagnosis, such as hypertension, was found. About one tenth indicate significant heart disease was present and not previously known. An example is, "Inferior wall ischemia by ECG. No significant history. Mother with ASHD. No D.M. in family. Blood sugar, cholesterol, triglyceride pending. Pt. will be followed and counselled. Thank you!"

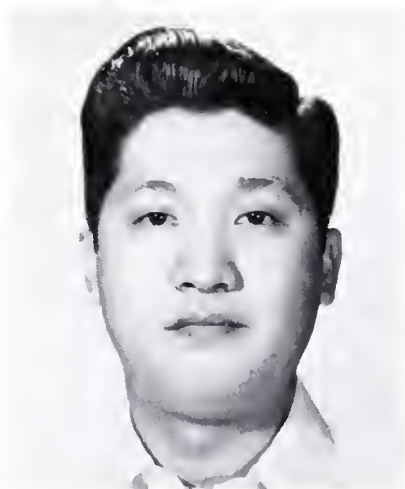
The "Thank you!" is for the donations that made it possible for the Hawaii Heart Association to provide this screening at a cost of less than 50 cents per person.

SAMUEL C. GRESHAM, M.D.

REFERENCES

1. Unpublished data, presented at Hawaii Regional Meeting of the American College of Physicians, February 18, 1970.
2. Walker WJ: A simple portable digital to analog device for ECG screening, *JAMA* 200:313-316, 1967.

New Members



Efren D. Baria, M.D.

1374 Nuuanu Avenue
Honolulu, Hawaii 96817

ANESTHESIOLOGY

University of the Philippines College
of Medicine—1962

Internship—Queen's Hospital,
Honolulu—1966-1967

Residency—Philippine General
Hospital—1962-1964

Bronx Municipal Hospital Center—
1964-1966



Paul Douglas Barry, M.D.

85-761 Farrington Highway
Waianae, Hawaii 96792

GENERAL PRACTICE

State University of New York
at Buffalo—1971

Internship—Queen's Medical Center—
1971-1972



Lee H. Falk, M.D.

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PSYCHIATRY

New York University Medical
School—1948

Internship—Beth Israel Hospital,
N.Y.—1948-1949

Residency—Menninger School of
Psychiatry, Topeka, Kansas—
1949-1950

Bellevue Psychiatric Hospital—
1950-1952



Robert Wylie Nemechek, M.D.

1133 Punchbowl Street
Honolulu, Hawaii 96813

ORTHOPEDICS

University of California
(San Francisco)—1962

Internship—H. C. Moffitt—

University of California—1962-1963

Residency—Fort Miley Veteran's
Administration Hospital—1963-1964

University of California Medical
Center and affiliated hospitals—
1964-1967



Deborah A. Putnam, M.D.

Queen's Medical Center
Honolulu, Hawaii 96813

G.P. (EMERGENCY)

Yale University—1969

Internship—Queen's Medical Center—
1969-1970



David H. Sakuda, M.D.

1507 S. King St., Suite 101
Honolulu, Hawaii 96814

RADIOLOGY

University of Washington—1964

Internship—Harbor General Hospital,
Torrance, California—1964-1965

Residency—Harbor General Hospital,
Torrance, California—1967-1972

HAWAII MEDICAL JOURNAL



James R. Langworthy, M.D.

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GENERAL PRACTICE

University of Michigan—1969
Internship—U. S. Public Health
Service Hospital, S.F.—1969-1970



Edward B. Lipp, Jr., M.D.

30 Aulike Street, Suite 506
Kailua, Hawaii 96734

ORTHOPEDICS

Thomas Jefferson University—1960
Internship—Lankenau Hospital,
Philadelphia, Pa.—1960-1961
Residency—Lankenau Hospital—
1961-1962
Tripler Hospital—1963-1966
Shriners Hospital—1965-1966
Walter Reed Hospital &
Johns Hopkins—1968



Dennis I. Maehara, M.D.

2080 S. King Street
Honolulu, Hawaii 96814

OPHTHALMOLOGY

Tulane University—1966
Internship—Southern Pacific
Memorial Hospital,
San Francisco—1966-1967
Residency—Tulane Ophthalmology
in New Orleans—1969-1972



Roy K. M. Sam, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

**PHYSICAL MEDICINE &
REHABILITATION**

UCLA—1966
Internship—UCLA Affiliated
Hospitals—1966-1967
Residency—UCLA Medical
Center—1967-1968
Wadsworth V.A. Hospital—
Los Angeles—1968-1970



Donald A. Sroat, M.D.

280 Alexander Young Bldg.
Honolulu, Hawaii 96813

OPHTHALMOLOGY

Northwestern University Medical
Center—1965
Internship—Chicago Wesley Memorial
Hospital—1965-1966
Residency—Northwestern University
Medical Center—1966-1969



Keijiro Yazawa, M.D.

2519 Coyne Street
Honolulu, Hawaii 96814

OBSTETRICS-GYNECOLOGY

Nippon Medical School—1962
Internship—St. Luke's Hospital,
Cleveland, Ohio—1965-1966
Residency—University Hospitals of
Cleveland—1966-1970

Book Reviews

WINFRED Y. LEE, M.D.

HAWAII
MEDICAL
JOURNAL

Handbook for the Orthopedic Assistant

By F. Richard Schneider, M.D., 198 pp., \$10.75, C. V. Mosby Co., 1972.

AS THE CONCEPT of the "Physician's Assistant" evolves from the theoretical and sporadic towards the practical and common-place member of the health care team, we can expect to see an ever-growing number of books and monographs as teaching aids and ready references for these technicians. This particularly, as the teaching of the subject matter becomes a part of the curriculum of post-high school educational facilities.

On first view Dr. Schneider's relatively brief and beautifully diagrammed monograph appears somewhat simplistic. In some portions the text tends to "talk down to" the reader. A more thoughtful look suggests that in fact very little which is of importance has been left out and the essence has been put in simple, definite and clear-cut terms so no one can really miss the point.

Most text books written for a new discipline or technology evolve slowly over a number of years and several editions. This book in contrast, covers a brief review of the musculoskeletal system, trauma to it, casting and traction techniques and their practical applications in a manner in which there should be little modification for many years to come exclusive of the effects of a major breakthrough in fracture therapy. The rationale of including a chapter on orthopedic history and physical examinations seems questionable unless the author plans in the future to expand his concept for the orthopedic assistant to an effective place in reconstructive orthopedics in children and adults. For that matter it is the omission of this entire subject which probably makes the book readable and brief, but also significantly distracts from its overall value. This compromise was obviously carefully thought out by the author and was most likely a wise one.

LAWRENCE H. GORDON, M.D.

★Therapy in Acute Coronary Care

By Barry B. White, M.D., 156 pp., Yearbook Medical Publications, Inc., 1972.

A VERY successful attempt at a textbook in coronary care, compared to most attempts in this area.

Dr. White has many good chapters in this soft-back edition, including an excellently presented outline on myocardial cell metabolism, both aerobic and anaerobic; an excellent section on the autonomic nervous system and its control of the heart; an important statement regarding the difference between primary and secondary arrhythmias after a myocardial infarction; an appropriate speculation regarding the fact that some premature atrial contractions in an acute M.I. patient may be the earliest sign of impending congestive heart failure; an excellent section on the therapy of pulmonary edema, arranged in the proper hierarchy of measures to be used; an equally good section on cardiac pharmacology; a provocative appendix on procedures and protocols for a Coronary Care Unit; and a useful glossary.

With roses should go brickbats: There is no mention of the importance of visual monitoring in the CCU, felt to be as important as electrical monitoring; there is a mediocre section regarding the differentiation and treatment of supraventricular tachyarrhythmias; there is no discussion of the re-entry type of premature ventricular contractions; a poor section on cardiogenic shock, its mechanisms and treatment; no mention of the importance of differentiating hypovolemic shock in this group, since it is so much easier to treat than the other causes; and some other small failings.

At this point, it should be said that the coronary care concept is, and will continue to be, a dynamic one. Ideas continue to change rapidly in this field and, perhaps, this is the reason that there is so much continued interest in it. Therefore, it is really impossible to write a good book regarding coronary care, since it is probably obsolete by the time it is published. This book was published in 1971.

In summary, this is an excellent attempt at what is probably impossible to do well.

EDWARD L. CHESNE, M.D.

★Management of High-Risk Pregnancy and Intensive Care of the Neonate, 2d Ed.

By S. G. Babson, M.D., and R. C. Benson, M.D., 313 pp., \$16.50, C. V. Mosby Co., 1971.

THIS COMPREHENSIVE BOOK is certainly a "must" in every pediatrician's and every obstetrician's library. Also, it should be in every hospital's delivery room and every newborn nursery and intensive care unit. Both pediatricians and obstetricians will benefit from this book by the complete understanding of the factors affecting the health of the newborn baby. Hopefully, this would improve the "communication" between obstetricians and pediatricians.

This book discusses in detail the many factors affecting the fetus in utero, then the complications associated with early births (prematurity) and the complications associated with late births (infections due to ruptured membranes, toxemias, diabetic mothers, isoimmunization, etc).

The last half of the book deals with the assessment of fetal maturity, fetal distress signs, and the intensive care methods necessary for effective, successful treatment. It is comprehensive and presented in a simple easy-to-read manner.

HENRY L. YIM, M.D.

Anaesthesia in Organ Transplantation

Edited by T. Hilary Howells, M.D., and Alan W. Grogono, M.D., 170 pp., \$19.75, Intercontinental Medical Book Corporation, 1972.

EXCELLENT AND complete book on the subject matter. Easily read and very informative.

C. CHOCK, M.D.

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★ means highly recommended.

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

September 22, 1972—5:00 P.M.
Mabel Smyth Conference Room

CALL TO ORDER

The meeting was called to order by President William Iaconetti. Present were: Drs. Iaconetti, Herbert Chinn, R. Varian Sloan, Grover H. Batten, George Goto; Winfred Lee, Denis Fu, DeWitt Smith and Douglas Bell were seated as councillors; and E. R. Ballard, Calvin Sia, Masato Hasegawa, Rowlin Lichter and Elisabeth Anderson; plus Messrs. Thomas Rice, Bob Nichols and Ralph Kiesling from HMSA, Hideo Matsushita and Dr. John Morris from Maui Medical Group, and Dr. William Goebert.

SPECIAL DISCUSSION

A special discussion on Health Maintenance Organizations was presented by representatives from the Maui Medical Group, HMSA, and Dr. Betty Anderson. A Community Health Plan (HMO) was established on an experimental basis by Maui Medical Group in February 1972 in cooperation with HMSA. Some of the highlights of the first six months of operation were shared with the Council.

MINUTES

The minutes of the September 1, 1972, meeting were approved as circulated.

SECRETARY'S REPORT

The secretary's report was approved as circulated.

TREASURER'S REPORT

The financial statement for the month of August and a cash flow projection through December 1972 were thoroughly reviewed. The Finance Committee recommends (1) that a cost study of staff time on the JOURNAL be carried out, (2) that the Convention Committee consider an increase in the annual meeting registration fee for nonmembers and that a study of fees charged in other states be undertaken.

ACTION:

The recommendations of the Finance Committee were approved. Interest was expressed in comparing the profit and loss statements of 1971 and 1972 as well as a breakdown of the travel account.

EMCRO REPORT

A position statement on EMCRO will be distributed at the next Council meeting. Several meetings have been held with EMCRO staff regarding future funding of the project. Very shortly, individual participating physicians will receive their first performance feedback.

DSSH MEETING

Dr. Iaconetti met with the Director of the Department of Social Services in an effort to reestablish some lines of communication. Meetings will continue.

CANCER COMMISSION

The contract between the Hawaii Tumor Registry and the Research Corporation of the University of Hawaii has been signed.

EMERGENCY MEDICAL SERVICES

A progress report on the EMS project was given by Dr. Chinn. The contract with RMP should be signed in the near future.

UNFINISHED BUSINESS

The transfer of the Hawaii Foundation for Medical Care to the State was discussed. Negotiating teams should meet soon.

NEW BUSINESS

Dr. DeWitt Smith asked for Council endorsement of a Hawaii County Medical Society resolution relating to the addition of county presidents as voting members of the Council.

ACTION:

The request was ruled out of order and it was suggested that the resolution be presented to the Constitutional Convention.

Mr. Thorson reported that Santa Clara County in California had expressed to Dr. Mills their desire to nominate him as AMA Trustee for the 1976 election.

ACTION:

The Council voted to support the suggested candidacy of George H. Mills as a member of the AMA Board of Trustees.

A request was received from Dean Terence Rogers from the University of Hawaii School of Medicine for the HMA's suggestions regarding the establishment of a training program for the 35-40 unlicensed physicians presently in the State who have failed the ECFMG examination.

ACTION:

Dean Rogers' request was referred to the Health Manpower Committee with the suggestion that they consider the cost of establishing a training program at the University of Hawaii versus the cost of sending these individuals to the mainland for training.

Questions were raised regarding the development of a Hypertensive Care Committee as outlined in the RMP Newsletter. Further information will be sought.

ADJOURNMENT

The meeting adjourned at 9:15 P.M.

R. VARIAN SLOAN, M.D.
Secretary

County Society News

HAWAII MEDICAL JOURNAL

Honolulu

The September 5, 1972 meeting was called to order by President Winfred Lee. Approximately 100 members were present.

Minutes of the June 6, 1972 membership meeting were approved as read by Dr. Albert Chun Hoon.

Dr. Lee welcomed to the meeting new members: Drs. James Dow, Ernest Platt, Raymond Taniguchi, John Thompson, Charles Tashima, and James A. Dennis.

The program included a discussion of a "Rapid Transit System" for Oahu. Dr. Walter Yokoyama introduced the speakers: Mr. John S. Detlie, Project Manager, Honolulu Rapid Transit Project; Rear Admiral E. Alvey Wright, Deputy Director, Department of Transportation; Miss Margaret Lucas, Advisory Specialist in Ocean Engineering, Sea Grant Office of the University of Hawaii.

Discussants envisaged a rapid transit system by comparing a fixed guideway system to a water way base system to a duo-mode bus system. The year 2010 was predicted for the completion of a fixed guideway system, the other two may not take as long.

Dr. K. S. Tom announced the deaths of two members of the Medical Society. The membership observed a moment of silence in memory of Dr. Joseph E. Strode who died August 13, and Dr. Edward C. Wo Lum who died August 21, 1972.

To keep the membership abreast of what is going on in the Medical Society Dr. Lee summarized some of the recent happenings as follows: The Society's bylaws are undergoing some major changes and will be presented in detail to the membership at the next meeting. Members of the Society have testified at hearings of the DSSH and DOH relative to proposed rules regulating fees for payment of physicians' services. Concerned members are making every effort to effect changes in the proposed schedule which is based on the 1970 RVS of HMA, but the conversion factors they wish to apply are below the going rate in the community. In spite of opposition from several agencies, the Medical Society, and the communities involved to the manner in which the grant was awarded, Kaiser has received \$1,000,000 from the National OEO to develop an urban-rural health services delivery system in three areas of Hawaii. Our peer review is functioning in all areas and any member who has an opinion about how to improve its effectiveness should convey his feelings to the staff or officers of the Society.

The October 3, 1972 meeting was called to order by Dr. Winfred Lee, President.

Those present included approximately 160 lawyers and doctors. The minutes of the previous meeting were presented by Dr. Moore, Secretary, and approved as read.

New members presented to the membership were Drs. James Langworthy and Audrey Mertz. Following the introduction of the new members, Dr. Lee introduced Mr. Philip Frey, attorney, who was to act as moderator of a panel consisting of attorneys Harold W. Nickelsen and Burnham H. Greeley and Drs. Chun-Hoon and W. Lee.

The topic of the panel for discussion was peer review and due process. The first panel member, Dr. Winfred Lee, outlined the peer review plan as now being put into the bylaws of the county medical society and described the mechanisms that were being developed to

provide an adequate and objective process of review of physicians and their performances.

Then, Dr. Chun-Hoon described how the plan would work and described the activities of the committees in regard to various types of problems that may come before them.

Mr. Greeley described due process from a legalistic standpoint and gave some interpretation of recent court rulings relative to the use of due process in the hearings before committees, etc.

Concluding, Mr. Nickelsen described the activities of the Bar Association and its relationship to the Supreme Court and how they handle a disciplinary or ethical problem.

Following the panel presentation there was a period of questions and answers that were fielded by each member of the panel under differing circumstances. At the end of the question and answer period the lawyers were excused to the lanai and the business section of the meeting took place.

Dr. Lee announced that the Waikiki Drug Clinic was in need of additional help and appealed to the doctors to volunteer for one night a month from 8 to 10 to assist Dr. Neal Winn in the administration of the clinic in Waikiki.

Dr. Harry Arnold, Jr., Chairman of Bylaws Committee, presented the proposed bylaws changes that will be up for consideration for the November meeting outlining the provisions that are recommended by the Bylaws Committee and the reconstruction of the committees and in redefining the membership classifications. The material will be mailed to the membership prior to the November meeting for them to study and review.

Hawaii

The September 21, 1972 meeting was called to order by President DeWitt Hendee Smith.

Members present were: Drs. Bracher, Oda, Loo, Okumoto, Carvalho, Ballerini, Mitchel, Casile, and Best. Guest speaker was Dr. John Mebane. Other guests were Drs. Carpentier, Padwick, Reardon, Irwin, and other members of the mental health clinic of Hilo.

The business portion was conducted first. Dr. Smith introduced a resolution supported by the members wherein the President of our County Society would be given a vote at the Hawaii Medical Association Council Meetings. The guest speaker, Dr. John Mebane, Director of the Hawaii County Mental Health Association, conducted an informal question and answer session in which the various avenues of his mental health program were discussed.

Maui

The regular monthly meeting was held at Club 19, Waihee Golf Course, on September 19, 1972. The scintillating personalities of the Auxiliary guests led by President Betty Rossberg, and Secretary Florence Achong brought an incandescent glow to the dinner meeting, edified by the presence of Lorraine Iaconetti and Gwen Fu, the prime movers of the presiding officers of the HMA and the MCMS, respectively. The food was very

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Life in These Parts

In the wake of the FDA pronouncement on brain damaged children from Phisohex bathing, the hospital pharmacy committee decided that department chiefs should sign general consent forms so members can continue using the brain damaging soap. When it was revealed that the surgical department was the greatest user, committee chairman **George Suzuki** commented, "I've been wondering about those surgeons. . . ." Fellow internist **Quint Uy** asked seriously, "Has there been any data on adults . . . especially surgeons?"

At a Board of Governors meeting, HCMS prexy **Wini Lee** smiled broadly as he announced that the pre-constitutional convention caucus would be held on October 30. When Wini warned, "It's the night before Hallowe'en," alert **Allan Pavel** was worried, "Is there any significance?"

Golfing enthusiast **Bill Hartwell** struggled through 17 holes of the windy, well trapped Kuilima course and made a birdie 3 on the 18th hole which helped recoup his losses. When we asked what he thought of those monstrosly deep traps to the right of the 18th green, Bill told the unlikely story of a WW II Japanese soldier being found recently wandering in the sand dunes. . . .

With the trend to move psychiatric patients out of institutions, the State Hospital occupancy had dropped from 1,200 a decade ago to a low of 230 patients. Recently 529 students of the Windward Oahu College moved into the hospital grounds and hospital administrator **Audrey Mertz** explained, "We hated to see all the space not being used. . . . There may be some interaction in the future by letting the hospital serve as the place for field work for psychology students and some patients perhaps taking a few courses." (Or with all the pressure on college students these days, perhaps a few may eventually become patients. . . . Perish the thought.)

Cal Sia has an aunt who wrote the book, "Life Is For a Long Time" which is all about Cal's grandparents, **Drs. Li Khai Fai** and **Kong Tai Heong** who at ages 21 set out from Canton to practice western medicine among their people in a strange new land—Hawaii. . . .

Jack Seaff, Jr. runs five to eight miles four times a week and is a member of the American Jogging Association, the National Jogging Association, and the local Community Fitness Program. Jogger Jack says, "We have the highest rate of premature heart disease in the world, and it's because of our sedentary lifestyle. If you want a heart attack, sit and smoke."

Hawaii was chosen as one of the nation's 15 cancer research centers because of its multi-ethnic population. The National Cancer Institute recently granted **Diek K. C. Lee** and **Fred Greenwood** \$292,045 (in addition to the \$188,000 awarded last year for development of a pilot center). Data collection and tumor registry will be centered at the State Health Department and research activity will be conducted at local hospitals.

We were happy to learn that the Hawaii Medical Political Action Committee has finally taken a bipartisan approach in the 1972 elections by donating \$200 each to both the Democratic and Republican contenders for congress, **Spark Matsunaga** and **Fred Rohlfing**. But the Republican streak is still showing for it contributed to 10 incumbent Republicans and to only 9 Democrats in the State House. . . .

Honolulu's St. Francis Hospital opened an outpatient artificial kidney facility at the Hilo Hospital where five patients will be treated. Hilo surgeon, **Shizuto Mizuire**,

rhetorically hailed the event as "a rare case of bringing the latest of medical facilities to the rural areas of the State."

David Eith, it seems, is a baseball fanatic. . . . Recently when he asked a patient how he got the scars around his ankles, the patient, former major league short-stop **Eddie Joest**, replied, "From playing baseball." David forthrightedly had him sign his baseball encyclopedia which he always keeps in the office.

When the Honolulu Magazine reporter queried **Fugate Don Carty** who has been spearheading the new Straub Hospital, "Can hospitals make money?" Don was frank and straightforward: "We built this hospital because we needed it to provide better medicine for our patients. And we hope the hospital will be in the black. Certainly it's true—not only with Straub doctors, but with the vast majority of physicians everywhere—making a living is important. . . . But it's not what turns us on!"

Our innovative PR chairman **Rowlin Liechter** was invited to the dedication ceremonies for the new Kona Hospital site. . . . Rowlin offered to bring along his favorite calabash bowl for the blessings. . . . "Are we going to put Holy Water in it?" "Well, no, that won't do." Nurse **McNichols** piped up, "We'll try a specimen."

Tom Thorson's Corner

The caliph was about to leave on a long trip. Being naturally worried about his harem of beauties, he summoned his chief eunuch and put him in charge. The chief eunuch proudly accepted the responsibility and the caliph departed, confident that his harem was in good hands. . . . When he returned several months later, he was dismayed to find half his harem unmistakably pregnant. . . . He again summoned the chief eunuch and demanded an explanation. "Well, sire, after you left, my mother became gravely ill and I had to leave my cousin in charge. . . . I guess he just wasn't cut out for the job. . . ."

The unmarried professor of family counseling was asked by his class what he would look for in an ideal wife. The prof thought only for a moment and replied unhesitatingly, "She would have to be an economist in the kitchen, an aristocrat in the drawing room and a prostitute in the bedroom." Several months later, he married and his class asked him if his wife lived up to his ideals. "Not quite. . . ." he replied frankly, "She turned out to be an aristocrat in the kitchen, a prostitute in the drawing room and an economist in the bedroom. . . ."

A woman in her late 40's felt sick to her stomach and went to see her physician. The physician examined her and announced sympathetically, "No wonder you feel so poorly. . . . You're pregnant." Furious at the thought of another pregnancy at her age, she phoned her husband at his office and said angrily, "You dirty ole man! You got me pregnant." Came a cautious whimper, "Who is this calling, please?"

Elected, Appointed, Honored

We congratulate the following: **Sam Wallis** of Kauai was reelected president and chief of staff of Wilcox Hospital for the 3rd consecutive year in August, and in September, was honored on the 35th anniversary of the Kauai Rotary Club as one of six charter members. . . . **William Holmes** was elected vice president of the Pacific Club. . . . **Bob Oishi** was elected director of the Better Business Bureau. . . . **Namiko Kominami** was

appointed to the 12 member Hypertension Information and Education Advisory Committee of the NIH. . . . **Raymond Dusendschon** and **Audrey Mertz** were elected to the board of the Hawaii Committee on Alcoholism. . . . **Al Shimamura** was reelected to the board of directors of Kuakini Hospital. . . . **Charles Guy** was appointed medical director of Hawaii Planned Parenthood. . . .

On the cancer front, the Oahu Unit of the American Cancer Society installed **William Hindle** as vice president. . . . The Hawaii Division elected **Reginald Ho** chairman of the executive committee, **Clifford Strachley** and **Drake Will** vice presidents, and **Sharon Bintliff** and **Ann Catts** from Oahu and **William James** from Maui new board members. . . .

Professional Moves

In this Year of the Rat, **Homo Sapiens Medicus** has been usually active since July and continues its migratory pattern even into October. . . . Moreover the dropping of the residency requirement appears to be unrelated to this phenomenon. In September, **Henrietta Tompkins** started her year's sabbatical, something she has done before. . . . **Henry Gotshalk** announced his retirement effective October 15 and **Charles Brown** moved into his office at Alexander Young Building. . . . With the passing of the likes of **Rogers Hill** and **Joe Strode** and now with Henry's retirement, we sense a passing of an era. . . . We recall all too well those days at Queen's when Henry was one of the few who could make any sense out of EKG tracings and would recommend appropriate therapy. . . . We also note with sadness the demise of the Alsup Clinic, but are happy to note that **Pat Walsh** and **Ed Boone** from the Clinic have joined the Honolulu Medical Group. . . . Internist **Winston Ueno** and dermatologist **Robert Clingan** have also joined the Group. . . . GP **Alvin Fuse** and internist **James Hirasa** joined **Joe Nishimoto's** group in Pearl City. . . . Surgeon **Hideo Tamaki** joined the Leeward Clinic and internist **Ben Leung** joined the Pali Medical Associates. . . . **Norina D'Iorio** joined the Mililani Medical Clinic and neurologist **Ronald Yamaoka** joined the Windward Medical Center. . . . A **Gerald Yorioka** joined the Haleiwa Medical Clinic, Inc. and neurosurgeon **Maurice Silver** relocated to Suite 357, Alexander Young Building. . . .

In October, ophthalmologist **Calvin Masaru Miura** joined the Kimata Clinic and psychiatrist **Lee Falk** joined **Ellis Devereaux**. . . . Dermatologist **Norman Goldstein** went from group to solo practice and located at the Alexander Young Building. . . . Surgeon **Sze-Ming Suen** joined the Waiialua Hospital and Clinic and GP **Kenneth Ho** moved from Vineyard over to 181 S. Kukui. . . .

Doctor Jokes . . .

The housewife was outraged at the \$70 bill from the plumber. . . . "Why," she complained, "My doctor only charges \$50 for a house call. . . ." "Lady," the plumber retorted reminiscently, "I used to charge \$50 too when I was a doctor. . . ." (**Wally Mitchel**, entomology prof at UH)

During surgery, the patient's penis was severed inadvertently. . . . In the recovery room, the surgeon explained to the patient, "I have good and bad news for you." "Let's rave the bad news first." "Well, your penis was cut off." The patient was stunned, but he screwed up his courage and asked hopefully, "What's the good news, Doc?" "The specimen was sent to the pathologist and he found it perfectly normal. . . ." (**Harry Arnold's** repertoire)

Sportsmen

The story of the First Annual Kapiolani Hospital Tournament is that chief of staff and golfer extraordinaire **Stan Saiki** who is also known as Pat Saiki's hus-

band of late. . . . **Phil McCallan** who arranged for the tournament at Kaneohe Clipper Course and who MC'd the post-tournament banquet at the Marine Corps base officer's club told how when he moved over to Kapiolani to be the building project superintendent, Stan gave him his first assignment, "Have a golf tournament." The entry fee was a modest \$20 donation to the Kapiolani-Children's Building Fund which paid for the green fee, the steak-lobster buffet and prizes to boot. Phil admitted, "I realize the gross for the day may not be enough . . . to cover expenses. . . . In fact we may be in the red. . . ." But we know the goodwill generated will more than make up for the losses. . . . As we started to explain, the story does not end with Stan initiating and running the tournament, but when the final count was in, he had won with a low net of 66. . . . After playing 15 holes of nearly flawless golf, Stan developed a bad case of tournamentitis. . . . He three putted the 16th for a buzzard, missed OB by 6 inches on his second shot on the 17th, muffed a chip shot, luckily two putted for a boggie. Then on the 18th tee with the engulfing darkness, no one saw where his ball went. . . . A frantic search of the premises and **Buster Richardson's** owl eyes uncovered the ball 20 yards past the green. Regaining the coolness of a pro in a tight situation, Stan pitched on and 2 putted for a boggie 4. Only then, could Buster, Don Maruyama and we, and of course, Stan let go with a big sigh of relief. . . .

Other winners included **Mike Okihiro** who shot a low gross of 76 (despite an unpredictable wood game) and pressure player **Dick Ho** won 2nd low net with a 78-10-68. **Joe Nishimoto** won the best putter award with 29 putts and the foursome of **Stan Saiki**, **Don Maruyama**, **Buster Richardson** and **H. Yokoyama** won the Best Foursome (total net) Award. . . . The Worst Foursome Award went to **Tom Oshiro**, **Toshihiko Kawasaki et al.** . . . which goes to show that if you're going to shoot badly, you should shoot really badly. . . .

* * *

It was the week before the annual Makaha Invitational sponsored by the Path Lab. . . . **Tom Kobara** and **Paul Tamura** with sadistic glee had pitted four regular tournament winners against each other. The gruesome foursome included **Joe Nishimoto** (HMA Tournament co-winner), **Herman Mercado** (Hawaii Pathologists tournament winner at Kuilima), **Stan Saiki** (Kapiolani Invitational winner) and **Ed Izawa** (perennial tournament winner and hole-in-one golfer). But Joe Nishimoto who had looked forward to winning the Makaha affair was laid up in a Kuakini Makai III bed with fever, dangling IV's and an isolation sign posted on his door. Frank Fukunaga and we stood in the doorway (careful not to step past the threshold lest the bug not honor this boundary) to cheer him up. Joe sounded charmed, but with characteristic bravado asserted, "I let them off the hook. . . . I hear everybody (in the foursome) was afraid of me. . . ." Frank commented wryly, "It's supposed to be a 'foursome of champions,' but it's more like a 'foursome of ringers.' . . ." Joe chuckled happily, fever, rash, arthralgia, IV's and all. . . .

Miscellany

Kublai Khan invaded China during the Sung Dynasty which was known for its mellow tea. . . . After taking the capital city of China, Kublai enquired anxiously if the tea was still available. . . . A subordinate reassured him, "Sire, the Sung has ended, but the mellow tea lingers on. . . ." (**Harry Arnold's** repertoire)

A father and son were involved in a serious car accident. The father was killed instantly, and the son, badly injured, was rushed to the hospital emergency where the surgeon took one look at the injured and declared forthright: "I can't operate. . . . He's my son. . . ." (Heard by **Phyllis Hashimoto** on the "All in the Family" show) (For those still confused, the surgeon was his mother. . . . This leads up to Tom Leineweber's following poem on women's lib.)

"Those women who call themselves Ms.
Assert the prerogatives of Hs.
Though clearly obsequious
In matters quite devious
They still cannot stand up to Ps."

Oncology Conference

When intern **Kheng Hua Lee** from Singapore described the 62-year-old woman with gall bladder CA as a Shinto priest, moderator **Noboru Oishi** quipped, "Let's not bring religion into the picture." Kheng Hua described her icteric sclera and attributed a medial squint to being kicked by a horse in childhood. Surgeon **Vie Mori** commented that the tumor "as very impressive in size and extent" and that he had no alternative but to relieve the obstruction by leaving a T tube draining bile externally. The problem was what to offer her next? Pathologist **Grant Stemmerman** was unusually quiet, "We don't have much to say on this. It is an undifferentiated carcinoma." There was an unprecedented gloom. . . . Noboru asked for suggestions. Radiologist **Ed Quinlan** was quite explicit: "Radiotherapy is unsatisfactory." Fellow radiologist **Carl Boyer** merely said, "No comment." When Noboru quizzed, "Do you agree or disagree?" Carl replied, "Both." Despairing, Noboru turned to fellow chemotherapist **Jack Keenan**: "What do you think?" Jack was no help either, "I don't think anything." Then it took a surgeon to think of something. **Bob Oishi** suggested, "Some people have suggested mixing the bile with tomato or orange juice." Then Jack brightened, "How about mixing the bile with 5 FU?" Surgeon **Shoyei Yamauchi** was quite rhetorical: "The main thing is to have her drink the bile."

A 57-year-old Japanese woman with recurrent gastric CA, liver metastases and liver pain had been treated with interrupted 5 FU therapy. Noboru asked, "What are the chances of relieving the pain with X-ray therapy in this area?" Carl Boyer was explicit: "Small, but finite." Grant Stemmerman interjected, "Joe Post in his recent talk pointed out that there is an increase of tumor cells in G1 and G2 states with therapy despite an overall decrease in tumor size. As soon as therapy is ceased, tumor cells return to normal. Once an individual is on 5 FU therapy, it must be continued if there seems to be a response. I know if I had a patient responding to 5 FU treatment, I wouldn't stop." Jack Keenan nodded, "I couldn't agree more." But when Grant added, "Tumor cells are not completely eliminated by chemotherapy," Jack defended chemotherapy, "I've seen tumors disappear completely and not recur."

A 73-year-old Japanese woman with carcinoma of the pancreas had a laparotomy and biopsy. When oral 5 FU was suggested by chemotherapist **Quintin Uy**, Francis Oda asked, "You all talk about oral 5 FU. . . . How do you give it?" Quint: "Same dose, same preparation. You mix it with orange juice." Jack Keenan added, "It tastes like bad medicine." Francis: "Preoperatively I asked Ed Quinlan if he would irradiate if I clipped it. Remember, Ed? Over a cup of coffee. . . ." When Ed looked blankly, Quint asked Francis, "Did you buy the coffee?"

Miscellany

Bumper sticker reminiscing the good ole days: "Remember when air was clean and sex dirty?"

In the days of knights and chivalry, King Arthur one day summoned Sir Lancelot and said, "I'm leaving on a journey. . . . I trust you above all men and I am entrusting you with the key to Genevieve's chastity belt." Lancelot replied, "I'm touched by your faith in me. I promise to protect her with my very life." Before an hour had lapsed, clippity clop, clippity clop, up gallops Sir Lancelot to the King's castle on his pure white charger, and announces breathlessly, "My Liege, my Liege, I am sorry to disturb you so, but you gave me the wrong key. . . ." (As told by Betty Anderson's spouse)

Aetna Medicare Review Meeting

Between review cases, plastic man **Vie Hay Roe** told the story of how he and **Jim Mitchel** of Hilo spent one whole morning doing a panniculectomy on a once obese woman who had lost so much weight that her loose abdominal skin draped down to her knees. Some weeks later during a postop followup visit, she revealed, "For a while, I felt there was something odd. . . . Then I realized that I was actually feeling air between my legs for the first time. . . ."

LQ Pang opined that a physician should be compensated for the extra time involved in taking care of the elderly and cited the case of a senile patient of his with many children, each of whom insisted on calling during office hours to find out about the parent. Our medical philosopher **Bernie Fong** was reassuring, "You'll make up for it by avoiding law suits. . . . The problem will resolve itself because people are having fewer children these days." **Vie Hay Roe** was equally unsympathetic: "All the time involved should be charged to professional courtesy. . . ."

We talked about the recent plague of retroactive denials of acute hospital care and how HMSA representatives were basing their decisions on nurses' notes rather than illegible physician scribbles. . . . **Gordon Liu** had a patient who developed severe kyphoses after being confined to bed for 3 to 4 days while being evaluated for a possible MI. The nurses' notes read, "Ambulates freely" and the patient's acute hospital care was retroactively denied. Gordon checked further and it turned out that the patient was "ambulating freely" with two nurses holding him up on each side. . . . **Bernie Fong** related how his patient with an acute MI developed a dissecting aneurysm as well. The aneurysm was successfully resected in spite of the acute MI, but HMSA officials denied the patient acute hospital care after the 7th postop day although guidelines for an MI called for at least 3 weeks of acute care. . . .

Eye man **Jerry Faulkner** reviewed the case of a patient with macular degeneration receiving once weekly injections of 75,000 units of Vitamin A. Aetna Medicare received a torrid letter from the attending ophthalmologist when the injectable Vit A was denied inasmuch as Medicare stipulates that injections are not allowable when oral preparations are available. Jerry admitted he searched the literature and asked his colleagues, re, the validity of Vit A therapy for macular degeneration and nothing substantial could be ascertained. . . . The claim was denied. We learned that the only allowable injections are injectable diuretics. On a Medicare-DSS patient of ours with severe osteoporosis and backache, we had given an injection of Deladumone and she kept coming back once every two weeks for more injections because it helped her so much. So we had cleared through DSS for permission, but not for long because we received the following elucidating note from a **Dorothy Whitaker**, DSS Medical Consultant: "I authorized you to give an injection of Deladumone to above patient on 9/13/72 without knowing that Medicare and therefore Medicaid had declared it ineligible on June 8, 1972. You will receive payment for this injection on this patient, but not on future patients." (Foiled again . . . even though we sit on the Review Committee.)

Allergist **Allan Young** reviewed a 65-year-old patient with neurodermatitis treated twice weekly for a 7-month period with routine ultraviolet treatments. . . . **Vie Hay Roe** felt, "Perhaps we should irradiate the physician instead. . . ."

Quotable Quotes . . .

"With all due deference to my profession, it is deemed wise to keep certain orifices open and others shut." Quote by **Tom Rice**, HMA legal counsel.

At a surgical conference where a case of ruptured rectosigmoid colon following a BE was presented, the ambitious surgical resident presented mortality statistics on

rectosigmoid injuries in the Civil War, the Boar War, WW I, WW II, and finally the Korean War, only to point out that mortality had dropped from 80% to 15%. Commented **Bill Shiraki** dryly, "All we need is another war to reduce the mortality to zero."

Physicians Speak Up

Hi-lites of the HMA-Hawaii Newspaper Agency forum "How Not to Kill Yourself with Fork and Spoon" with moderator **Rowlin Lichter** and panelists **Ed Chesne**, **Wini Lee** and **Dave Eith** (as reconstructed from news reports).

Ed Chesne: "While the cause of obesity is unknown, the obese person is more susceptible to heart disease earlier in life and is more extensively affected than the person who is not overweight. . . . For some people, overweight is not a question of cosmetics, but a question of life and death. . . . Studies have shown that heart attacks tend to occur more often in animals whose weights have fluctuated from normal to obese than in those kept at a steady weight. . . . If you are going to lose weight, lose it and stay down to prevent arteriosclerosis."

Wini Lee: "Very overweight persons have hormonal changes including a decrease in growth hormones and an increased insulin level that promotes fat formation in the body. That's why a fat person has a harder time losing weight, because the body tends to keep rather than burn the fat and that's part of a fat person's frustration."

The following was extracted from Tomi Knaeffer's descriptive article: "Lee, who is inclined toward plumpness himself, got a round of applause when he admitted to dieting and losing eight pounds—'despite four parties—after I found I was going to be on this panel. . . . I know it's hard,' he said, addressing the fatties in the audience. 'Our society makes us eat . . . by making food look so good. But don't blame them. It's their business. Technology makes it too easy for us and more and more we sit in front of the TV and reach for food with the right hand. . . . But it's your problem and you have to do something about it. Otherwise, it's just words. . . . I know many of you came here tonight wanting a magic answer. . . . But there's no easy answer.'"

Dave Eith: "Weight reducing regimens differ with individuals. . . . I prefer to prescribe a 1,000 calorie diet plus regular vitamins and diuretics to eliminate excess water in the system. . . . Fad diets—whether water, sex or Rockefeller diets—are worthless if they are not nutritional and if they allow a person to gain weight immediately after he goes off. . . . One way to keep weight down is, when you head for the icebox, don't shoot for the goodies on the top shelves, but reach down into the vegetable bin. . . . You can eat vegetables to doomsday and about all you'll do is die of malnourishment."

Rowlin objected to Dave's remark that milk should be a steady diet for adults, and Dave conceded that skim milk was preferred. When Rowlin continued to insist that milk was not necessary at all for adults, Dave countered with "Neither is cigarettes, booze or sex."

At the Fifth Asian-Pacific Congress of Cardiology, in Singapore, **Abe Kagan**, director of the Japan-Hawaii Heart Program, reported that heart disease is more common among migrant Japanese in Hawaii and that richer food and cigarette smoking appear to be the main culprits. "There is a definite implication that people in the West eat too much rich food. . . . Cigarette smoking is one of the worst things people can do to themselves."

Marion Hanlon of Maui spoke at a FBI National Academy Associates conference, "Police and Youth Today" and opined that the "generation gap is more myth than fact. . . . Our teenagers have their own ideas—the gap between them is as much as between adults. . . . Perhaps, we, as adults, create the generation gap—if there is such a thing—and we should treat young people with love and concern."

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George Mills, president of the State Association of Hawaiian Civic Clubs, reported that the 34 Hawaiian Civic clubs distributes over \$40,000 annually for scholarships for Hawaiian youngsters.

Bob Fisher, head of the alcohol and drug abuse section of the Department of Health, reports that Naloxone, an antagonist drug that totally blocks out the effects of heroin, is being studied as an alternative to the widely used methadone. Bob says, "Methadone is not the panacea of all drug abuse."

In response to a question by Kokua Line, **George Starbuck** of Children's Hospital says, "Verbal abuse can be more damaging than a broken home. A child who is always shouted down soon gets to feeling nobody loves him, and he becomes very depressed."

A Douglas Doyle was incensed by political shenanigans which permitted the driveway installed in front of the Kobe Steak House at 1781 Ala Moana which has resulted in a dangerous pedestrian situation. "I believe the political appointee who gave the permit for this driveway leading to nowhere should be exposed and be held liable in court for any casualties caused by this situation. To me this smacks of the worse type of political favoritism against the rights, privileges and safety of the public."

Miscellany

"*Nobody is Perfect*. Each one of us is a mixture of good qualities and some perhaps not-so-good qualities. In considering our fellow men, we should remember his good qualities and realize his faults only prove that he is, after all, a human being. We should refrain from making harsh judgment of a person just because he happens to be a dirty, rotten no-good son-of-a-bitch!" (From a plaque hanging in the HMA office)

When we mentioned that "Gone With The Wind" was being re-run at the Cinerama, our 6th grader son asked, "Is it a show about a horse?"

A small midwestern town had the highest birth rate in the country. Public health officials investigated this strange phenomenon and learned that the 6:15 Southern Express was the culprit. As one inhabitant pointed out, "It's too darn early to get up and too darn late to go back to sleep." (As related by Betty Anderson's spouse)

"Dear Diary: I went to the psychiatrist and stayed over an hour and he never asked me once to lie down. . . . I guess if you are going to suffer rejection, that is the place. . . ." (From Aku's program)

Hors De Combat

Last October, **Frank McDowell** received a coveted award, a 8¼ by 7¼ inch crystal undulating disc from the American Society of Plastic and Reconstructive Surgeons at its annual banquet in Montreal for outstanding work in the field. On August 24, while Frank was out of town, the Steuben Glass creation was stolen from his Kailua beach home. He put the following ad in the papers with a photograph of the award: "\$250 cash reward for immediate return of this glass trophy! No questions asked!" And, he got it back thru the St. Christopher's Episcopal Church in Kailua. (Truly, an act of God. . . .)

Our favorite women's libber, **Mary Glover**, had a no-holds-barred running battle with the City to allow her to continue practicing out of her little white cottage in Nanakuli. The Zoning Board of Appeals finally succumbed and granted Mary her variance. Now she is turning her sights to another Waianae Coast need, a 50-bed hospital. . . . (So beware. . . .)

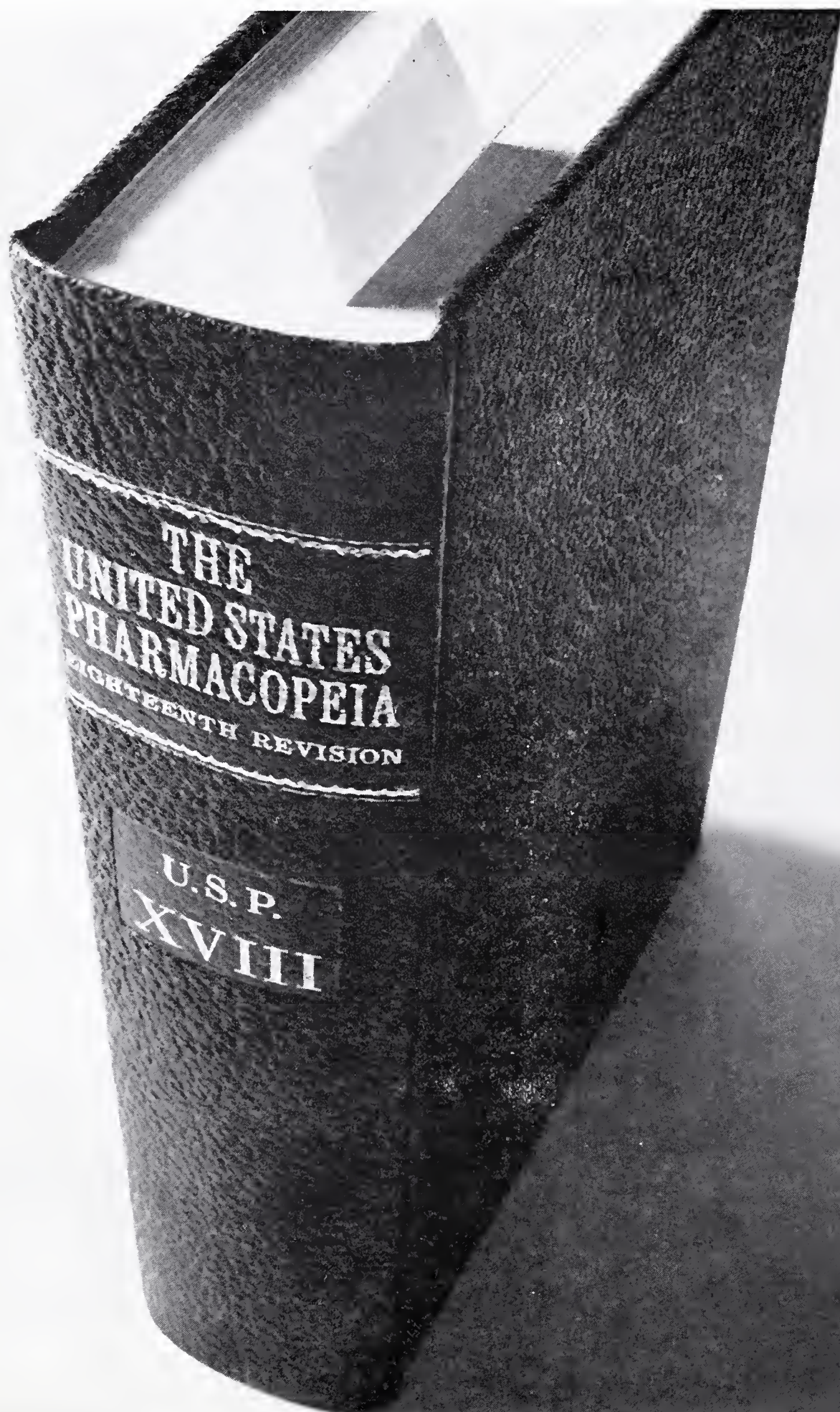
When **Henry Manayan** announced plans to demolish his 28-bed nursing home on Pacific Heights and build an 82-bed home, the citizens of the heights reacted, but were later acquiesced by the architect's residential type design and the assurance that the home would blend with the neighborhood. . . .

During the recent public forum, "How Not To Kill Yourself with Fork and Spoon," panelist **Wini Lee**

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Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)

Menopause (natural or artificial)—PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.

Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (e.g. atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.

Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.

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Notes and News *continued from 493*

quipped that he had a sure-fire 100% way of not killing oneself with fork and spoon—use chop sticks. . . . Ed Chesne was introduced by moderator Ron Lichter as "the only cardiologist in town who smokes" and Ed took a last deep drag on his cigarette. . . . Dave Eith, another panelist, mentioned the sensuous diet as one in which the more sex one has, the more he loses in weight. Looking at Ron Lichter who of late is looking trimmer, he recommended, "If anyone is interested in this diet, talk to Ron Lichter." Wini Lee added this tidbit. In other societies, the menopause is a welcome event for it heralds the end of a woman's child-bearing years and from then on, "Sex is fun!" (As reported by John Won)

Visiting Physicians

Leo Gelfand, internist turned lawyer after 20 years of practice, spoke on "Medical Malpractice" at the Kaiser Medical Center annual symposium and listed the following reasons for the increase in malpractice suits:

Lack of personal relations. . . . People have become estranged from the idea of the family doctor and look at doctors as highly specialized and expensive technicians. . . .

Unqualified medical practice, particularly in the area of surgery. . . . Only board certified and board eligible surgeons should do surgery. . . .

Medical associations generally don't do their own policing and permit physicians who aren't qualified and who make repeated mistakes to go on and on repeating mistakes. . . .

Physician image. . . . Many persons identify physicians

as big money makers and see them as fair targets for suits. . . .

Leo's recipe for avoiding malpractice suits include the following recommendations:

Don't be too hasty in turning over overdue bills to a collection agency or sue for payment. I suggest instead that physicians, as in any other craft or business, accept a certain amount of loss. . . .

Courtesy and interest—call it bedside manner—go a long way. A patient wants to know that his doctor is interested. . . .

Don't attempt procedures you're not qualified to do. . . .

Whenever a patient is very sick, always call in one or two other physicians for consultation. The family of a patient dying likes to feel that everything that can be done is being done for the patient. . . .

Doctors should cope with unethical colleagues who prescribe or sell pills without legitimate cause. . . .

Doctors should practice medicine and not make their money on the basis of hospital admissions and X-ray orders. When patients learn this, they feel exploited and in some instances, they may be correct. . . .

✓ ✓ ✓

At a USC postgraduate course in August, Lawrence Weed from the University of Vermont College of Medicine scored our present medical record keeping and advocated a problem oriented system in which the patient is given a copy of his medical records. He maintains: "Doctors got screwed by the medical schools that put them out to practice without giving them the tools so they can grow and grow together. . . . Medical schools turn doctors out with the idea that facts or content is enough, rather than giving them a system and the training to look things up all the time, to find answers, and to follow things up thoroughly. . . . For lack of a sys-

continued page 503

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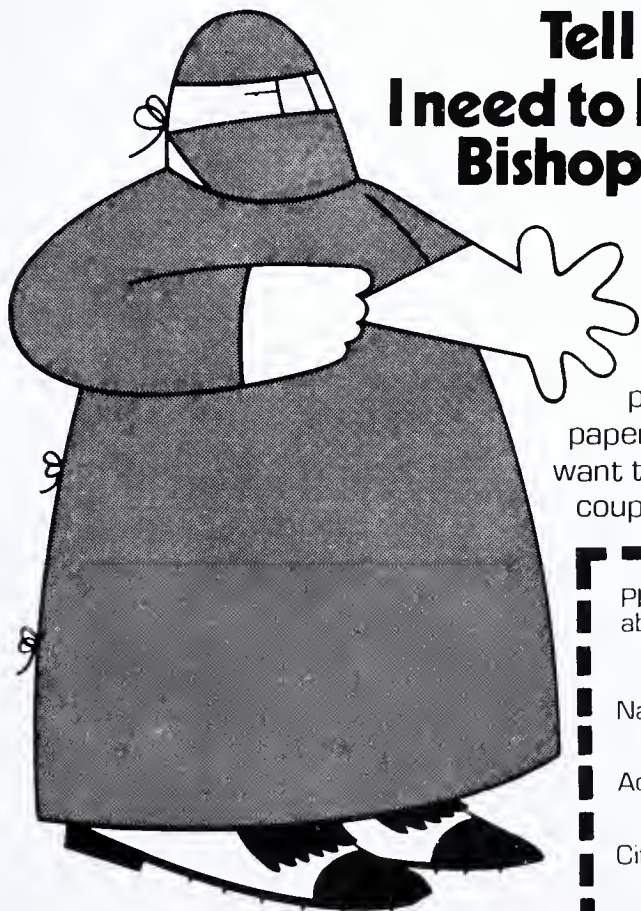
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What it means to live and work in Tipton County, Tennessee

Persons who are white and
over 40 have one chance in four
of having solar keratoses...
which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons
over 40 in Tipton County, Tennessee**

Female	159	44
Male	117	66

☐ Persons without solar keratoses ☒ Persons with solar keratoses

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

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Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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estly and honorably to bring about the resolution of problems of the GP by using rational arguments and promoting commonsense attitudes to dampen the swing of the pendulum from one extreme to the other.

The common aim of the medical profession is for the welfare of the patient. The AAGP represents an effort to make the GP assume his proper position on the team that will continue to accomplish that purpose.

J. I. FREDERICK REPPUN, M.D.

Slants and Angles continued from 481

limits to man's ineptitudes. For the computer, the limits I believe are not so obvious. Used in ignorance or stupidity, asked a foolish question, it does not collapse; it goes on to answer a fool according to his folly. And the questioner, being a fool, will go on to act on the reply."

Computers conveniently ignore those values and qualities which are not capable of precise measurement, observation, and scientific expression. Yet, this device has become the symbol of a technology that succeeded for two centuries by moving in complete indifference to nature and by ruthlessly suppressing, when necessary, man's feelings, intuition, and imagination. The inevitable result has been a violent polarization of our society into two groups. On the one side are the mechanists, the technocrats, the "Establishment." On the other side we find the mystics, the naturists, the "Movement." While dissent rages between these two groups, we seem to face disaster on all fronts: ecological, social, political, psychological, moral, and spiritual. It seems as though the past and the future are coming violently together in our time to shatter the prevailing order of society.

THE TURNING POINT

The present decade sees us approaching a climax, a critical turning point in human cultural evolution. There have been only a few such turning points in the long history of Western man. Some ten thousand years ago he changed from a wandering nomadic life to the cultivation of crops: the Agricultural Revolution. Two hundred years ago saw the beginning of the Industrial Revolution, with man changing from a predominantly rural to an urban, industrialized city life. A mere twenty-five years has brought the technological revolution to its present peak at a time of unparalleled dissent, apathy, and alienation.

What lies ahead just around that bend in the road we are so fast approaching? There seems to be only three possible futures awaiting us. The first is an ecological nightmare of overpopulation, famine, continuing pollution of air, water, and soil, and finally and inevitably biological extermination.

The second possible future finds technology triumphant over the human spirit with man becoming a dehumanized robot. This is the ultimate realization of Huxley's *Brave New World* and Orwell's *1984*. There occurs a subtle shifting of power from the people to the technocratic international managers, with technology branching into the behavioral sciences to develop new and efficient systems to control the population. Politics becomes political management, citizens become subjects, and man is enslaved.

Both of these futures are, of course, unthinkable, and we must urgently seek and find a viable alternative.

SHAPING THE FUTURE

This new future must have as one of its guiding principles nonpollution; we must do more with less. There should be limits to growth and a return to simplicity. We must bring about the harmonious integration and mutual enrichment of science, religion, nature, and art, as well as the humanization of technology.

Who will be the leaders of this new society? The somewhat uncomfortable answer is that all of us are going to be, for to be viable this must become a true participatory democracy. Just as war is too important to be left to the generals, so government is far too important to be left to the politicians.

What about our particular interest and concern, the delivery of health care? How must this be changed and adapted to meet the needs of the new society? One of the problems of medicine today has been eloquently expressed by Carl Binger, "at the very time when our knowledge of human personality and its development has taught us so much about man's need for trust, for closeness, for belongingness, for relatedness, and for love, medicine has become more and more mechanized and depersonalized. As a time when anxiety is wide spread, when the sense of emptiness has become the mood of the day, and the word "alienation" is part of the common usage, medicine seems to have turned its back on the vagaries and vicissitudes of human beings in their struggle with destiny and to have focused instead on their enzyme systems."

Here, I believe, is a plea for relevance in medical research and for the treatment of whole

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*** Grade II diabetic retinopathy is revealed
by the small hemorrhages and exudates
in this photograph of the fundus.**

human beings rather than diseases. Every individual born into this society must have the opportunity to fulfill his whole potential as a human being. We must restore the security of strong personal relationships. People must feel that they are valued and respected members of a group, not things to be cast aside when they have outlived their usefulness. As physicians know, hearts can stop from lack of love, as well as from lack of oxygen. Health care must be prevention-oriented rather than crisis-oriented. There must be concern for the community, as well as for the individual.

The task before you is to help shape this new society. It is a difficult task but the human spirit triumphs in trouble and adversity. We live in a difficult time and yet an exciting time full of danger, hope, challenge, and change. Bend yourselves eagerly to the task before you, my friends, for as Thomas Carlyle said, "this world after all our science and sciences is still a miracle; wonderful, inscrutable, magical, and more, to whomsoever (sic) will think of it."

W. P. JONES, M.D.

SUGGESTED READING

1. *Overskill*, Schwartz, Eugene S., Balantine Books, 1972.
2. *At the Edge of History*, Thompson, William L., Harper & Row, 1971.

County Society News continued from 488

appetizing but the portions were restricted to the accepted calorie requirements. The dinner conversation was quite animated and almost dominated by our female conferees (M.D.'s*). The other members of the evening's galaxy were Ginny Moran, Fumie Uehara, Lois Haling, Ilona Briley, Mary Jo Dietrich, Betty Fleming, Penny James, Olive Cole, Marge Sowers, Lucille Peat and Joyce Romero. Bill Patterson and Ed Underwood the only "bachelors" of the evening.

As President Fu signalled the serious portion of the program, the Auxiliary retreated to an adjacent room. Minutes of the August 15 meeting were approved as circulated.

The HMA Health Careers Day on October 18 was discussed. \$100.00 was approved for half of the round trip fare of five Medical Explorers and an adult chaperone; the other half to be paid by HMA.

The Medical Explorers Post advisor informed the Society that of the 22 Explorers last year, five were accepted as pre-med students in reputable colleges on the mainland.

The transfer of Dr. Louise Geise from the California Medical Association to Maui County Medical Society and the membership of Dr. William G. Kepler were both accepted.

The case of an individual advertising "remedial tutoring and testing of perception disabilities of children" with alleged endorsement by a member of the Maui County Medical Society was lengthily discussed by Drs.

* M.D.—Marriage Degree.

Briley, Underwood, Uehara, Peat and Fu. The consensus was that said individual should not be allowed to function alone in isolation nor do therapy unless testing is requested by M.D.'s. Dr. Briley was assigned to check the individual's training and authenticity and President Fu volunteered to write the Board of Regulatory Agencies regarding the licensing of this activity (orthoptics).

Councilor Uehara reported that a Constitutional Convention will be held on November 4 and 5, 1972. There is a move to increase the representation of the neighbor islands to the Council and also add the County Society Presidents as members. This will require change in By-laws for the county to pay for the additional expenses. One objection is that the Council will become too large. The term of councilors is also recommended to be either indefinite or limited to six years and that the County Society should nominate its own councilors instead of the Board of Delegates doing it as is presently done.

President Iaconetti of the HMA urged delegates to do their homework before going to the Convention.

Dr. Wong expressed desire to relinquish the Chairmanship of the Diabetic Program to either of the other members: Drs. Percy and Sowers.

Dr. Withers was appointed Chairman of our coming Christmas Party. Dr. Moran will object to any move to hold the party at FU KU TU!

The three last Presidents were appointed as a nominating committee for next year's slate of officers.

The subject of Medicare EKGs, when introduced, was like opening Pandora's Box. The gist of the meeting between Mr. Grathwohl of Medicare, and Mr. Romson of Maui Memorial Hospital was to write the diagnosis that will justify payment for pre-op EKG. A list of diagnoses acceptable to Aetna is available. Drs. Rossberg, James, Moran and Underwood vehemently expressed disapproval of the gist: Not right! Dishonest! Even a pre-op EKG on a bleeding ulcer was disallowed! Stupid! Why should we even have a blood count?

The cool-headed HMA President tried to soothe the hotheads by saying that Medicare has a panel of Internists in Washington who had set the policy on EKGs and many doctors in Honolulu are adding the justifying diagnosis.

Have the tentacles of federal control and socialized medicine finally reached the back door of the most remote family physician? Shall we allow this monster to strangle our freedom to take care of our patients the best way we know how without a fight? Now is the time for our complacent and lapse members to come, stand up, and be counted in defense of the American way of life. At no other time in the history of America is this maxim more appropriate than now! *United we stand, divided we fall!*

Book Reviews continued from 486

Also Received

Notes on Clinical Method

By the Clinical Teachers of the Manchester Medical School, 140 pp., \$2.88, Manchester University Press, 1971.

THIS HANDBOOK is intended as an introductory guide for students embarking on clinical medicine.

Review of Medical Microbiology, 10th Ed.

By Ernest Jawetz, Joseph L. Melnick, and Edward A. Adelberg, 518 pp., \$8.00, Lange Medical Publications, 1972.

AN EXCELLENT HANDBOOK for those who desire a concise review of this subject.

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tem, medicine today is running wild with no feedback. . . . The medical record preserves the doctor's logic. . . . Without medical records, there can be no control over the quality of medicine because it's like having a football game with no rules and then, anyone can claim he has a touchdown. . . ."

* * *

At the same USC refresher course, R. Bruce Sloane, head of USC's Psychiatry Department, declared that "the phrase 'Till death do us part'—may well be outdated. . . . The phrase was invented when people's life expectancy was short, when the role of women was different, and when the family's place in society was also different. . . . Today with life spans averaging in the 70's it is conceivable that a person in the 20's is not the same in the 30's or 40's. So the marriage entered into at one time as all enduring may not be as true in this age. . . . Marriages inevitably change, as women become equal partners. . . . Under the present morality, a whole series of different relations existing between men and women may be foreseen. . . . The liberated women expect the male to be sexual athletes and the young men feel they need to perform as prize studs. . . . The result of women taking the Don Juan role is causing an increasing incidence of impotence among these young men. . . . Sexual incompatability is the second biggest cause of divorces—next to sheer immaturity. . . . Maybe there's some sense to the idea advanced by young people that couples ought to live together and get to know each other before thinking of marriage. . . ."

At yet another session, R. Bruce stated that he is against the legalization of marijuana at this time, but favors the reduction of penalties for marijuana possession. "It's too early to tell what the long term effects are. . . . The only way we're going to know is after time

passes. . . . There is no evidence that marijuana usage will lead to hard drugs, but not enough is known about so many other facets. . . ."

re, books on teenage problems: "Stay innocent. Don't bother with the books. Just do what comes naturally. . . . Often it's better not to analyze why a door is working well. Just enjoy it."

HMA Outreach continued from 480

As everyone knows HRI with hundreds of amendments affecting Medicare and Medicaid passed last month with additional benefits and controls over both facilities expansion and medical services. Drs. Iaconetti and Mills for the HMA (Frissell, and others on their own) attended November's Clinical AMA Convention in Cincinnati where many pressing issues and new developments will be discussed. A review of *PSRO's* as well as *Peer Review Mechanisms* were to be discussed and explored at length in special AMA-sponsored meetings.

* * * It is a very busy time when THOUGHTFUL, COOPERATIVE efforts by ALL physicians working together is ESPECIALLY needed if the problems facing medicine today are to be carefully and wisely resolved in the best interests of all concerned.

ELISABETH K. ANDERSON, M.D.

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The 16th Congress on Administration sponsored by the American College of Hospital Administrators will be held February 22-24, 1973 at The Palmer House, Chicago, Illinois. For additional information write American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago, Illinois 60611.

AMERICAN COLLEGE OF PHYSICIANS 1972-73 POSTGRADUATE COURSES

These courses are arranged through the cooperation of the directors and the institutions involved. Registration forms and requests for information are to be directed to: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

January 8-10, 1973

THREE DAYS OF LIVER DISEASE

Woodruff Medical Center of Emory University, Atlanta, Ga., to be held at Royal Coach Motel, Atlanta, Ga.

February 8-10, 1973

RECENT ADVANCES IN THE IMMUNOPROPHYLAXIS AND CHEMOTHERAPY OF INFECTIOUS DISEASES

University of Arizona College of Medicine, Tucson, Ariz.

February 26-March 2, 1973

CLINICAL GASTROENTEROLOGY

University of Michigan Medical Center, Ann Arbor, Mich.

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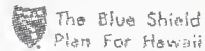
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Building block molecules (purines, pyrimidines, sugars, lipids, amino acids)
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Nucleic acids
DNA synthesis
Expression of genetic information
Regulation of gene expression
Biochemical aspects of differentiation
Organ morphogenesis
Intermediary metabolism
Bioenergetics
Evolution of proteins
Cell membranes
Neurobiology
Overview of genetics

In addition to the lecture presentations informal office discussions in small groups, on an elective basis, will be held with members of the faculty:

Paul Berg, Ph.D.—Tumor virus
Howard M. Cann, M.D.—Genetics and disease
Stanley N. Cohen, M.D.—Bacterial antibiotic resistance
John W. Farquhar, M.D.—Atherosclerosis
John H. Frenster, M.D.—Tumor immunology
Halsted R. Holman, M.D.—Rheumatic disorders
Norman Kretchmer, M.D., Ph.D.—
 { Growth
 { Inborn errors
 { Digestive enzymes
Joseph P. Kriss, M.D.—Nuclear medicine
Joshua Lederberg, Ph.D.—Genetics: opportunities and problems
John A. Luetscher, M.D.—Hypertension, renin, and aldosterone
Luigi Luzzotti, M.D.—Chromosomes and disease

Roy H. Maffly, M.D.—Salt and water
Thomas C. Merigan, M.D.—Interferon
Linus C. Pauling, Ph.D.—
 { Biology of water
 { Nutrition
Judith G. Pool, Ph.D.—Blood coagulation
Peter Ramwell, Ph.D.—Prostaglandins
Eugene D. Robin, M.D.—Molecular transport
Robert T. Schimke, M.D.—
 { Enzymes and their actions
 { Hormones and their actions
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Description: Spray-dried tomato powder containing 20 mEq potassium (equivalent to 1.5 Gm KCl) per measured dose with natural and synthetic flavors, spices and colors. Benzoic acid and potassium benzoate added as preservatives. When reconstituted as directed, makes a pleasantly flavored, low sodium tomato juice drink.

Indications: The prevention or correction of potassium deficit, particularly when accompanied by hypochloremic alkalosis in conjunction with thiazide diuretic therapy, in digitalis intoxication, or as the result of long-term corticosteroid therapy, low dietary intake of potassium, or excessive vomiting or diarrhea.

Contraindications: Potassium is contraindicated in severe renal impairment involving oliguria, anuria or azotemia; in untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps, hyperkalemia from any cause.

Precautions: Kato Powder is a concentrate and should be taken only after reconstituting with water as directed. Do not use in patients with low urinary output or renal decompensation. Administer with caution; it is impossible accurately to assess the extent of potassium depletion, or the daily dose required. Excessive dosage may result in potassium intoxication. Frequent checks of the clinical status of the patient, ECG and/or plasma potassium level should be made. High plasma concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. Use with caution in patients with cardiac disease.

Adverse Reactions: Vomiting, diarrhea, nausea, and abdominal discomfort may occur. Gross overdosage may produce signs and symptoms of potassium intoxication: mental confusion, listlessness, paresthesia of the extremities, weakness and heaviness of legs, flaccid paralysis, hyperkalemia, ECG abnormalities, fall in blood pressure, cardiac arrhythmias and heart block. The characteristic changes in the ECG are disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Toxicity: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Treatment of Hyperkalemia: 1. Dextrose solution 10% or 25% containing 10 units of crystalline insulin per 20 Gm dextrose, given I.V. in a dose of 300cc to 500cc in an hour. 2. Adsorption and exchange of potassium using sodium or ammonium cycle cation exchange resin, orally or as retention enema. 3. Hemodialysis or peritoneal dialysis. 4. Elimination of potassium-containing foods and medicaments.

Warning: Digitalis toxicity can be precipitated by lowering the plasma potassium concentration too rapidly in digitalized patients.

Administration and Dosage: Mix with water to make a pleasant tomato juice drink. The unit dose packet and the dose-measure supplied in the can each provide 20 mEq of potassium. Usual adult dose—1 packet or 1 measure of Kato Powder mixed with about 2 ounces of water twice daily—supplies 40 mEq potassium per day. Take with meals or follow with ½ glass of water. Larger doses may be required, but should be administered under close supervision because of the possibility of potassium intoxication.

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8 oz can (40 doses) with 20 mEq dose-measure.

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